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ORIGINAL ARTICLES.

INVOLUTION FORM OF THE TUBERCLE BACILLUS AND THE EFFECT OF SUBCUTANEOUS INJECTIONS OF ORGANIC SUBSTANCES ON INFLAMMATIONS.

SAMUEL G. DIXON, M. D.

Prof. Robert Koch announced in 1882 the discovery of the cause of Tuberculosis. He claimed that consumption was produced by a *peculiar bacillus of a special shape*. This he described as a rod-shaped micro-organism with rounded ends, either straight or curved, and frequently beaded. This simple form was accepted as a constant character until the summer of 1889, when I first observed, in an artificial culture on an Agar Agar glycerin nidus, a slight inclination to bud in one or more places along the rod, without the production of any particular angle, some relations forming an acute while others formed a right or possibly an obtuse angle. A single bud could only be recognized with a high power objective focused and illuminated with particular nicety. The indications, however, were so often repeated in each field as the slide was moved upon the stage of the microscope, that I was sufficiently convinced of the presence of branches to review the life-history of the tube in which they were found and to speculate upon the factors likely to have brought about the evident volution. The result was the production of germs with decided *branches*, some of which were quite as long as the parent rods or stems.

This result was published in *The Medical News* of October 19th, 1889. In

1891, Prof. Allen J. Smith observed branched forms of tubercle bacilli in human sputum. Since then Prof. Klein, Herren Fischel, Mafucci et al., have described the branching of this germ. In the summer of 1892 I observed the bacillus in this cycle of life in the liver of the Green Jay of Mexico, *Xanthoura luxosa*. This discovery, coupled with my observations of 1889, and corroborated by the statements of other scientists, must now compel the bacteriological world to recognize a more complex form of the tubercle bacillus than that observed by the great German bacteriologist in 1882.

Since the discovery of the branched form of the tubercle germs in 1889, I have been able to continuously reproduce them on artificial mediums. While the young germs seem to be quite simple in form, appearing in straight rods and rods bent upon themselves, those which have arrived at the age of four weeks, particularly in the presence of an excess of glycerin and in a temperature of 40° C., become branched. The young bacilli, when introduced into the animal tissues, produce tuberculosis, while the older cultures gradually lose their virulence, in all probability owing to their inability to reproduce themselves. This fact indicates that the branched form represents an involution life-cycle of the germ. Notwithstanding the fact, however, that the devitalized,

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dying or dead bacilli cannot produce consumption, they, with their products, effect a decided increase in tubercular inflammation, which inflammatory process even results in necrosis of the tissues.

These phenomena led to investigations proving the correctness of the hypothesis first published in my Monograph on Immunity (*Medical News* of Oct. 19, 1889) to wit: "It is possible that, by a thorough filtering out of bacilli from tuberculous material, a filtrate might be obtained and attenuated so that by systematic inoculations a change might be produced on living tissues that would enable them to resist virulent tubercle bacilli." In this line of experimentation I proved that the presence of the germs was not necessary to produce the hyper-inflammatory condition of the tuberculous tissue but that it was a *product* of the bacillus that caused the reaction upon the tuberculous animal tissues. This, since called *Tuberculin* and introduced into the human economy for the purpose of curing tuberculosis, when introduced into animals suffering with artificially produced tuberculosis, often destroyed the condition called consumption and in many cases appeared to produce immunity to the poison of tuberculosis. The process, however, was not quite so successful in animals which had contracted tuberculosis through one of the natural channels. In these cases, tissues surrounding that which was recognized as tuberculous afterward became infected with consumption.

While this was and still is discouraging we have good reason to believe that *Tuberculin* will be permanently established as a remedy for this pathological condition. The toxic albumose causing inflammation of tissues markedly tuberculous, coupled with the fact that it is found in such tissues, led me to inquire whether or not some other constituents of animal tissues, pathological or normal, would produce reaction if introduced in excess into the general circulation. This line of experimentation was begun by first using an albumose of the goat, a comparatively immune animal. This material, however, if at all active as a remedial agent in tuberculosis, is so slow in its effects that I have heretofore failed to produce any marked changes. When, however, in the course of my investigations I overloaded the animal system with some of its waste

products, Dr. William L. Zuill, M. D., D. V. S., who has kindly carried on the clinical work on animals for our Bacteriological Laboratory, reported in the *Times and Register* of Sept. 26th, 1891, a reaction by the Amide group on inflammatory tissues, the animals experimented on being tuberculous. As this group included that which we believe to produce the inflammation of gout, I was led to review my experience with tuberculosis in relation to lithemia. Studying this field with the lithemic and tuberculous habits in view, I was soon impressed with the fact that when these diseased conditions were present at the same time in any individual we could claim it to be an exception to the rule.

To determine the special action of the Amide group upon inflamed tissues when introduced into the circulation, a case of *Lupus vulgaris* was selected and first treated by the subcutaneous introduction of .03240 Gm. of Kreatinin, alternated twice weekly with .130 Gm. of Taurin, urea and uric acid. The average temperature during treatment was slightly raised, though not to any very marked degree, under the influence of such small doses. The more recent patches of lupus, however, became markedly inflamed, being accompanied with a burning sensation. On the third day after the first injection, a marked granulation could be detected around the outer edge by the aid of a strong amplifying pocket glass. This apparently healthy granulation has continued for ten days, in which time the patch has one half of its original area healed. The result shown at this early stage of the experiment is sufficiently encouraging to warrant not only a continuation of the treatment in this case, but in other forms of tuberculosis.

The only other subjects upon which these injections have been tried have been cases of pulmonary tuberculosis in a very advanced stage, where there was too much lung-tissue already destroyed to warrant the expectation of a favorable result. The fact that we apparently have an action on the lupus and no marked result with small doses on advanced cases of pulmonary tuberculosis causes me to realize that the line of experimentation must not be confined to tuberculous inflammation, but extended to the action of these organic substances on the entire group of inflam-

matory growths, the effect being produced possibly, by supplying that in which the pathological tissues are deficient.

This line of inquiry, which had its origin in Bacteriological Laboratory of the Academy, has opened up a new and wide field of important scientific medical investigation. The main object of this communication, at this time, is to confirm the original dis-

covery of the *branched form* of the tubercle bacillus by recording the observations of the same life-cycle of that micro-organism found in animal tissues. I have, however, ventured to advance theories and results regarding the action of substances far removed from the bacillus, because they were suggested during my studies of the branched form of that organism.

THE APOTHEOSIS OF DIRT.

WM. H. LINK, M. D., PETERSBURG, IND.

When St. Paul first entered the city of Athens, the most striking object to greet his eye was the altar erected to the Unknown God.

The intellectual Athenians having personified every passion, every science and every art, and assigned to each its presiding deity, thought to further promote their own welfare by appealing to the unknown, at the same time in doubt whether they should invoke its beneficence or propitiate its power.

The principle of worshiping the unknown and deifying the mysterious was not peculiar to Athens; nor was it either lost or forgotten during the Dark Ages.

Imagination, the most potent faculty in the advancement of man along any line of achievement, like all power may become potent for evil as well as for good. For "the lunatic, the lover and the poet are of imagination all compact," and whenever "it is a condition and not a theory that confronts us," the theory appealing to the imagination finds its priests ready to serve at the altar whatever be the doctrine.

The history of medicine in its advance from the crudest empiricism of the Egyptians to the brilliant and startling triumphs of Jenner, Pasteur, Lister and Koch, furnishes numerous examples where the imagination, disdaining facts and scorning experience, ran riot with the truth and turned back the wheels of progress.

The mutations of time cannot destroy the golden thread of truth running through all the cycles of medical hypothesis in which working theories are invented by the few and embraced or rejected by the many. While this golden thread is lengthened out from age to age

there is its complement of error running in parallel lines. Error being always bolder, more positive and certain than truth, it follows that the medical millennium is very far off when the devil of prejudice and ignorance shall be chained for a thousand years.

It is a peculiar fact which shows the slow advance of scientific knowledge among the masses, that about the time the profession have discarded some theory or abandon the methods growing out of it, the laity will usually have just begun to adopt its worst features and to embrace them with a zeal born of discovery.

The history of the clumsiest practices arising from the wildest theories may be traced in the methods of the common people, who are ever at least an age behind the profession. We often smile at the wise suggestions of some neighbor or old woman, made with all due solemnity, and supposedly in the interest of the patient whom we at the time may be treating. Yet if we would only look backward a few decades, we might find in the teachings of the profession plenty of authority for what the old woman or officious neighbor advocates. All of us in country practice, can recall the many filthy recipes foisted upon the sick in our absence, such as the famous "sheep nanny tea" for measles, urine for "thrash," rattle-snake and earthworm oil for rheumatism, dog meat for consumption, and dried horse-dung as a styptic application for freshly incised wounds.

There was a time, not long past, when tincture of hog-lice and like delicacies were prescribed by the profession with a firm faith in their healing virtues, on the

principle that the more nauseating and filthy a thing, the more certain and striking its therapeutic results. The omniscient genius of Shakespeare has amply illustrated the confidence reposed in the power of such concoctions for good or evil. In *Macbeth*, he describes the witches' brew, in which the dynamic influence of the incongruous elements was intensified by the mysterious mummery of enumerating

"Fillet of a fenny snake
In the caldron boil and bake;
Eye of newt, and toe of frog,
Wool of bat, and tongue of dog,
Adder's fork, and blind-worm's sting,
Lizard's leg and owl's wing,
For a charm of powerful trouble
Like a hell-broth boil and bubble."

Our homeopathic brethren yet appeal to the imagination of their followers with triturations and solutions of snake poison and tarantula juice, while we regulars occasionally prescribe *Blatta orientalis* with a like result, if not from like motives.

On this principle we can understand why any doctrine, whose foundation is cleanliness and whose gospel is purity, has such a struggle with error and such a fight with prejudice. "Ashes to ashes, and dust to dust," is a sentence passed upon all creatures alike, but too many try to execute the sentence upon themselves ere they "shuffle off this mortal coil."

These ideas, prevalent as they are among the major part of humanity, are not likely to produce any effect beyond emesis so long as they are confined in their application to the internal medication of the sick.

It is when applied to the practice of obstetrics and surgery that disaster follows in their wake.

It is the presence of crude notions, the distribution of ignorance and superstition, the influence of the mysterious and the hold which precedence has upon the imagination that enables midwives to ply their calling, even in localities where enlightened and scientific physicians abound.

In the natural world phenomena constantly occur which are paralleled by close analogies in the moral world. Geology tells us that in the great cataclysms of past æons where whole genera have become extinct, there is often a single species left to call attention to the myriads that have become destroyed or that have disappeared in the ordinary course of evolution. Reasoning in this way some of our naturalists suppose the great modern sea serpent is

nothing more nor less than a last remnant of those ancient monsters that swam about in prehistoric seas as gigantic sea-lizards. The botanist is sometimes agreeably surprised to find a plant representative of the carboniferous ages when gigantic ferns left their skeleton markings in the buried coal measures.

In the same way the midwife and the faith doctor stand to-day—living representations of that mythological period in medicine when totems, artificial thunder, and various preparations of filth and venom banished disease whether the demoniac or some other equally absurd pathological theory obtained. As the midwife was then she is to-day. As she is in one locality she is in another. Even now when medical schools have thrown open their doors to women and men alike, the midwife exists with the divine attributes of ubiquity and immutability. She is the same yesterday, to-day, and forever, and she is everywhere offering and giving her services to rich and poor, high and low. Thus

"With equal pace impartial Fate
Knocks at the palace and the cottage gate."

The streptococcus of erysipelas, the staphylococcus pyogenes—both aureus and albus, the bacillus of Lœfler all laugh when she appears, for they recognize an old friend who is to transplant them to virgin soil. The gonococcus of Neisser has been known to "prove up" on a quarter section of her vagina, and larger bugs like the pediculus pubis and the pediculus vestimentorum have been reported to have "staked out a claim" on her person, while she is always "at home" to that noble old Roman family the *Cimex Lectularii*.

She is one who is graduated into her calling by a variety of circumstances and a number of qualifications.

There is usually in every community some old woman who has a husband to partially support. Being poor and ignorant she is ready to half eke out a meager subsistence by turning her hand to any little odd jobs around the neighborhood. She "cleans the guts" at hog-killings for half the soap-grease. If any old sheep of a neighbor farmer dies, just as soon as it gets ripe enough for the wool to slip, she picks it on the halves. For these and other reasons, she soon has a reputation as one whose stomach nothing can turn.

Having once established a character of this kind she is immediately in great demand for dressing any specially virulent old sore or ulcer which persons in her vicinity may happen to possess. She not unfrequently has some wonderful salve which will do most anything from drawing a nail or splinter out of the foot to "healing all burns without a scar." The basis of this ointment is always both cheap and nasty, being most often the excrement of some one of the domestic animals; the favorite menstruum is usually goose grease and the corrigens and adjuvans may be anything from elder-bark to fried "cow-cumbers."

When anyone near her dies she is always the first one called upon to wash and lay out the corpse. Finally the time arrives when she is to meet the crowning triumph of her life, to put the cap-sheaf on her career, to add a new laurel to her wrinkled brow—the final accolade, to which all her other experiences have been gradually but surely leading her, and for which they have been just as certainly and thoroughly preparing her. Some woman in labor hurries up, or the doctor is delayed, and the child is ushered into the world with no help but Aunt Handy, who at one bound has become a mid-wife, with all that the name implies. She cuts the cord, smears the stump with some of her favorite salve and then proceeds to make the mother comfortable by taking a pull on the part of the cord left hanging out of the vagina, while kindly having the patient walk around the room to assist nature as much as possible. In order to save the bed she puts some old dirty quilt under her charge, while a due regard to her clean linen causes the patient to go through the parturient process dressed in clothing that nothing can soil.

Our newly fledged midwife has several qualifications soon added to those vouchsafed her by the long course of training she has undergone, which give her peculiar strength in a way. Having suddenly become what her ambition had long led her to hope for, she "fixes up" for the business. Heretofore her wardrobe for state occasions consisted largely of a calico dress. But it had one defect, it showed dirt, and had to be washed once or twice ere it succumbed to the ravages of time and travel. She now invests in something "all wool and a yard wide" which will not

show dirt, and which may be worn for years without washing. This being her "Sunday-go-to-meetin' dress" she wears it only when laying out the dead, nursing some bad case of erysipelas or child-bed fever, or when waiting on a parturient woman.

Her hands are hardened by toil and seamed by exposure, and her nails being useful in picking wool and doing other labor, are not always "trimmed to the quick" nor free from a suspicion of real estate. Handkerchiefs not being plentiful in her wardrobe, she wears a long apron to protect her dress and to wipe her hands and blow her nose on. The latter act she deftly robs of its poetry by turning the under side to the front and depositing the accumulated secretion of the schneiderian membrane on the part of the apron thus newly exposed; she then gives it a rub or two between thumb and fingers in order to spread it over as much surface as possible, for drying if not for cosmetic reasons. The apron is then dropped till necessity compels her to repeat the performance.

Being thus equipped she is at once the personification of filth, the apotheosis of dirt, the concrete exponent of ignorance and the coefficient of sepsis. She ought to be suppressed by law unless she will become properly educated for a correct and safe discharge of her responsible duties. When she is thus instructed she will be an accomplished physician; for the very highest medical knowledge and skill are essential to a proper and safe discharge of the duties devolving on the obstetrician; and it is utterly impossible for an ignorant and half trained mind to grasp even the science of the mechanism of labor, much less the many physiological, pathological and other questions which pertain to parturition.

We often hear that a young man has the ability to carry on a certain line of business. If carefully analyzed we believe this ability will be found to consist of

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| 1. Honesty. | 4. Sobriety. |
| 2. Industry. | 5. Consistency. |
| 3. Economy. | 6. Prudence. |

The last of these will prevent him from investing in an outside enterprise unless he can afford to lose the money should it prove a failure.

CLINICAL LECTURES.

GYNECOLOGICAL CLINIC, BUFFALO GENERAL HOSPITAL.

MATTHEW D. MANN, A. M., M. D.

DYSMENORRHOEA.

A young woman comes before us suffering with dysmenorrhœa. The case has proved intractable and it is one of true dysmenorrhœa, the pain being due to the menstrual function. I want you to start in practice with the idea that all the pains which a woman may suffer at the time of menstruation are not the pains of dysmenorrhœa. I recall a case of ureteritis accompanied by continual pain which became intolerable at the menstrual epoch. Such pain accompanying but not directly due to menstruation should not be called dysmenorrhœa.

Menstruation may be defined as a periodical loss of blood from the uterus and, therefore, the pain of dysmenorrhœa must be due to a cause in the uterus itself. In this case the pain never disappears during the menstrual period, but it is increased at times and there are occasional exacerbations of pain with spasms.

On making an examination I find that the uterus is acutely anteflexed and, on passing a sound into its cavity, I meet with a distinct constriction at the internal os. This is not due to flexion for when I straighten the uterus the instrument still passes with difficulty and "jumps" over an obstruction at the internal os. The passage of the sound causes great pain, especially as it touches the internal os. The patient has a few little clots come away at each menstruation and it is their passage over the supersensitive mucous membrane in the vicinity of the internal os that causes the exacerbations of pain.

Having this definite anatomical basis for the dysmenorrhœa we can, in all probability, effect a cure by relieving the condition. I shall, therefore, curette the uterus, dilate the canal and straighten the axis of the uterus by the dilatation and by packing with iodoform gauze. I do not believe that anteflexion alone will cause pain, for I have seen many marked cases of anteflexion without dysmenorrhœa, but anteflexion, by increasing the congestion of the uterus, may indirectly increase the dysmenorrhœa. The real cause of the

dysmenorrhœa is an endometritis, and this may be aggravated by the congestion. Forcible dilatation and packing of the uterus will merely change its position. While the anteflexion will not be entirely cured by these means, the sharp angle will be removed and this source of pain will be obviated, while, indirectly, the endometritis will be benefited. You will remember that last week I curetted a uterus on account of granulations with excessive menorrhagia—an entirely different condition from the mild endometritis here present.

The hymen prevents the introduction of the large blade of the speculum. It will stretch, however, sufficiently to admit the small blade, so that there is no need of rupturing it. With a little traction on the forceps I can pull the cervix into view. On attempting to pass the uterine sound I came up against a distinct constriction, but by bending and working the sound I get it through the constriction. The grating of the instrument over the rough endometrium can be felt distinctly, and if the patient were not under the influence of ether she would suffer greatly from this maneuver. The dilatation of the uterine canal is begun with Palmer's instrument which is not very powerful because the ends bend and, as you see, they have slipped out. I next introduce Goodell's powerful dilator. There is a graduated scale to indicate the degree of dilatation, but it is on the wrong side of the instrument for our convenience since, by the inventor, Simm's speculum and the Simm's position are rarely used, the patient being placed in the lithotomy position and the cervix exposed by means of a short bivalve speculum. I dilate the cervical canal gradually to the extent of $1\frac{1}{2}$ inches in order to introduce Holt's cervical speculum. The contractile force of the cervix is still so great that the speculum is forced out, and along with it a large quantity of jelly-like mucous, which is proof positive of cervical endometritis. I have now reintroduced Holt's speculum and, through it, the

uterus is washed out with a bichloride solution. In using Simm's position it is important to have the upper knee slightly in advance of the lower one so that there will be a space for the water to run down without wetting the patient's garments. The uterus is now curetted, sponged out with absorbent cotton and then packed with iodoform gauze, the cervical speculum being used to facilitate the passing of the gauze into the uterus. The gauze will be left in place four or five days unless it comes out spontaneously, sooner.

OVARIAN CYST.

Here is a small ovarian cyst which I found, buried in a mass of adhesions, deep down on the right side of the pelvis. I found a line of cleavage in the adhesions and, as they were not very dense, I succeeded in passing my fingers under the tumor and in gradually enucleating it. On pulling the tumor out of the abdomen I found that the pedicle was small. There was no bleeding of any account and I inserted no drainage tube. From some unaccountable cause the patient developed a high temperature, 104.5° , but the pulse never rose above 110 and, as the patient was of a very nervous temperament, I did not feel much alarm. The temperature remained high for three days and then dropped to normal. Strangely enough the patient referred her pain to the side opposite that of the tumor.

UTERINE FIBROID.

Here is a large fibroid tumor which was removed a few days ago by supra-vaginal hysterectomy. You can see the cavity of the uterus at the plane of section at just about the internal os. The diagnosis was properly made, the woman was suffering so much that she was willing to run almost any risk to get well. The pedicle was secured by the clamp. The patient is doing well, having had only a slight rise of temperature.

MULTILOCULAR OVARIAN CYST.

This is an ovarian tumor whose exact nature I was unable to diagnose. It proves to be a multilocular cyst, but even now, putting my fingers first on it and then on the soft uterine fibroid, I can distinguish no difference in the sensation. The moment that I saw the tumor through the abdominal incision I could tell by its bluish color, that I had to deal

with an ovarian cyst, the fibroids being of a dark color and congested. I was obliged to make a rather large incision in order to get the tumor out, otherwise the operation was a simple one. One of the little cysts had burst in the abdomen and some mucoid material had escaped into the peritoneum, causing a slight local peritonitis. The only way in which I could remove the tumor was to open it and clear out some of its contents, thus diminishing its size sufficiently to render its passage through the abdominal wound possible. The fibroid weighed four pounds and a half; this cyst about ten pounds with the fluid. The patient is doing well.

OVARIAN CYST, UTERINE RETROVERSION.

There is nothing especially interesting with regard to this specimen in itself. It is simply an ovarian cyst of considerable size. There were four adhesions in front; the growth had been rapid, dating back only eight months. The pedicle was at least six inches broad but very thin, so that there was no difficulty in disposing of it. The interest centers in the condition of the uterus, which, at the first vaginal examination, was found pressed down by the weight of the tumor into a state of retroversion. The diagnosis was verified at the time of operation and, after removing the cyst, it was found that the round ligaments had become stretched so much that there was no effort on their part to hold the uterus up in place. To have sewed up the abdomen with the uterus in that retroverted position would have caused needless suffering, especially if the uterus were to be kept functionally active by the presence of an ovary. In this instance I removed both ovaries, but whether that is done or not, I think it is the duty of every operator, after removing a tumor from the pelvis, to carefully examine the position of the uterus, and to correct it, if such correction be necessary, before he closes the abdomen. For I believe that even after the removal of the ovaries a retroversion may cause trouble. On this point I insist most strenuously. Young operators especially are too apt to be content with the completion of the originally planned operation, and to leave the correction of such a comparatively small matter as a displacement unattended to. This is all wrong. We should leave nothing undone which may count for the

future welfare of the patient. All the pelvic organs, the whole abdominal cavity in fact, should be carefully explored, and any pathological condition which may be found, corrected at the time, provided it is amenable to surgical treatment.

Now, in this case, I found that by pulling on the round ligaments I could bring the uterus into proper position; hence the indication for relief was clear. The first operation for shortening the round ligaments was brought into notice by Alexander, of Liverpool, and is generally known by his name. I attempted this operation very soon after its introduction into this country. At first I failed to find the round ligaments. But, after careful dissection on the cadaver, I met with no trouble; especially after I had adopted the plan of opening the inguinal canal and seeking the ligaments within its borders. Still my experience with Alexander's operation has not been happy. After finding the ligaments I have several times discovered them to be adherent, or too weak to bear pulling out. The patients have also, in several instances, experienced great pain and "pulling" in the scar afterwards, so that their last state has been as bad as the first.

From these experiences, and from the fact that Alexander's operation takes no account of any possible co-existing disease of the uterine appendages, I have almost entirely given it up. The number of my cases have not been large, and I would not like others to draw too positive inference from my experience. I am myself open to conviction in the matter, and am willing to take it up again if I see good reasons for so doing, and especially if the element of doubt can be removed from the result. I have, however, yet to see the operator who does not sometimes meet with failures, and only recently an acquaintance told me that he had seen five failures in the Women's Hospital, of New York, from this operation.

It is certainly not a desirable operation when we have the abdomen open and the round ligaments accessible. There are three or four different plans of shortening the ligaments under these circumstances. We may lap the ligament on itself and take a couple of stitches so as to hold the folds together. Inflammation and consequent adhesion of the peritoneal surfaces of the ligaments will bind the folds

together. I prefer silk sutures as being more permanent. This is Wylie's operation. Polk's operation consists in doubling in both round ligaments just in front of their attachment to the uterus and sewing the two loops together. If, at the same time, the loops are sewed to the fundus uteri by a stitch running under each ligament and through uterine tissue (Dudley's operation) the attachment of the ligaments is made to a higher point of the uterus where they have a mechanical advantage in overcoming the tendency to posterior displacement. In this case there was a little fibroid tumor the size of a marrow-fat pea in just the right spot for the attachment of the ligaments. I removed the fibroid, controlled the hemorrhage by pressure and stitched the ligaments to the uterus at this place. There was still a little oozing which I controlled with persulphate of iron, for any exudation in front of the uterus would require a separate drainage-tube from that placed in Douglas' cul-de-sac, and I did not want to put in two tubes. There was considerable oozing from the abdominal wound, so that it was necessary to insert a posterior drainage-tube, but this was removed after twenty hours.

Even if you do not do laparotomies yourself these points will be of service to you. The specialist to whom you take your cases may be one who does not pay much attention to displacements, and it would be perfectly proper for you to insist that at the time of operation he should correct the displacement of the uterus. The correction of the displacement does not complicate matters at all at the time of the operation and it adds greatly to the chance of perfect recovery later. I am treating cases at this very day which, I believe, would have recovered completely had I corrected the uterine displacement at the time when an ovarian tumor was removed. Text-books have not yet begun to insist on this point, but I have called attention to it several times in the last two or three years. The time is past when we simply looked out for the life of a patient at a laparotomy. Good operators lose not more than four or five per cent. of all kinds of cases. We must have in mind the entire future welfare of the patient and do everything at the time of operation that will exert a favorable influence on the general health of the woman.

COMMUNICATIONS.

HYDROPHOBIA.*

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I feel reasonably certain that what I have to say on this occasion will, to some extent, antagonize the views of a large majority of the medical profession and, therefore, I shall expect criticism; but this is the common lot of all searchers after truth, and just in proportion as the investigations of these searchers after truth or facts tend to upset popular fallacies, so in that ratio is the criticism of their efforts liable to be more or less unjust. I know of no more difficult or thankless job for the truth-seeker or man of science than to endeavor to upset a popular fallacy. Most persons say in the language of Shakespeare:

"Until I know this sure certainty,
I'll entertain the favored fallacy."

My sole object is to work in the interest of truth. Notwithstanding the much landed words of Lord Justice Knight Bruce, that "Truth, like all other good things, may be loved unwisely, may be pursued too keenly and cost too much;" I say, let us get the truth and the facts in all matters coming under our investigation, cost what they may. I have no higher God to serve than truth, and no lower and baser hell to fear than falsehood.

Hydrophobia is generally used by the profession and the laity to indicate a disease, when in fact it is only one of the symptoms of a supposed disease. Dunglison says, "The term rabies is more appropriate for the aggregate of symptoms resulting from the bite of rabid animals. Hydrophobia literally signifies a dread of water; and, consequently, ought to be applied to one of the symptoms of rabies rather than to the disease itself." I, therefore, prefer to use the term rabies in this discussion.

At the very threshold I assert that there is not now, nor ever has been, any such disease as rabies outlined and defined with any certain and definite symptomatology. I have not found a line in any

of the medical literature to which I have had access during the past thirty years, by which I could certainly and definitely identify any morbid condition as rabies. This name was born with the very beginning of medical literature, but neither the medical profession nor the laity have been able to identify the disease bearing the name, beyond all doubt. It is an illustration of how unfortunate it is "to name the child before it is born." We have the name, rabies, but where is the disease? Compare the symptoms, the evidence required thirty or forty years ago to make out a case of rabies with what is required now, and you will find there is no substantial agreement.

If rabies ever existed it does now, and conversely, if it does not now it never did. True disease, a disease entitled to the dignity of a name, must represent some unvarying morbid change in some element of the physical or mental organization. For example, diphtheria, small pox, etc., were the same in the seventeenth century as to-day; they are recognized by the same symptoms now as then, and these symptoms depend upon certain recognized, stable, morbid processes. But upon what stable, recognized or certain symptoms can we determine the existence of rabies? I insist that the evidence to identify rabies in court, either physical or rational, is all along the line simply negative. If there is any positive testimony, where and what is it?

In seeking to find out some definite way to diagnose this so-called disease, it is sickening and discouraging to read the great and numerous contradictions found in its clinical history, as given in medical literature by the best writers of the past and present time. If those who take a different view of this subject will, unbiased, read this literature, I think they will at least conclude with Dr. Brill, of New York, that the existence of the disease called rabies has not yet been proven. After referring to cases clinically reported forty years ago as

*Read before the Central Texas Medical Association, January 10, 1893.

well as at the present time, he says: "These cases are sufficient to show the variable character of the clinical histories, and serve to uphold the statement, which I have elsewhere made, that no two cases of this alleged infectious disease are alike; also that the symptoms of rabies considered to be characteristic of the disease by the earlier writers are not mentioned as such by those of the present day. Its alleged etiology shows as great discrepancy and absurd statements as could possibly be mentioned." A little farther on he says: "The animal, some claim, need not be rabid to produce the disease. Others deny this statement; some assert that the disease can originate in the animals named, (meaning the canidæ, mustelidæ and felidæ), *de novo*; others deny this absolutely and ridicule such a belief." He then says: "We deny to-day, as we denied some years ago, that there is any specific infection from the bite, or, that the existence of the disease in the dog has been sufficiently well established."

I admit, because it is a physical tangible fact, that disease and death result from the bite of dogs, mad from any cause. But, I contend, that it has not been proven in any logical or otherwise satisfactory way, that the cause of this so-called disease is from any specific infectious poison of invariable qualities, introduced into the system by the bite of a dog. In my judgment rabies is a hypothetical disease for which the whole world has been trying for centuries, and trying unsuccessfully, to establish an entity. Where, I ask, is the microbe of rabies? I have not heard that it has been identified in any court of competent pathologists! And, where is Pasteur and his treatment of rabies to-day? I have not read anything from him for some months, but not a great while ago, he was still as usual changing his views on the subject and swearing by the last as the only treatment. If he keeps jumping it will be difficult to overtake, much less keep up with him. However, I have a good word and a warm place in my heart for Pasteur. Perhaps he has demonstrated that, pathologically speaking, there is no such disease as rabies, and, therefore for this, if for nothing else, humanity owes him a debt of gratitude.

It is my opinion now that all deaths in animals such as the dog, wolf, cat, etc., from the so-called rabies, could be more

satisfactorily accounted for by diseases and injuries well-known, and explained by proper pathological and physiological investigation, without wasting time trying to make an entity for rabies. It is an indisputable fact that whenever a domestic animal, as the dog is sick so as to lose his common sense, the laity, and far too many doctors, at once say it is *mad*—has hydrophobia, and can be killed none too quickly. Then and then only follows the great and most serious cause of trouble for human beings, and this is *panic*. This panic is not confined to the patient himself, but it extends to all of his associates as well. It grows in seriousness and intensity with each day. There is no one to even attempt to allay it. Well-meaning but misguided friends tell of all the horrible deaths from rabies of which they have ever read or heard; the doctor looks wise, as usual, and it may be sympathetic, and, in as kind and loving manner as possible tells the patient, his relatives and friends that there is no cure for it, that it always ends in death of the most painful and excruciating character and that it may come at any time in from 9 days to 9 or 100 years! Given the same panicky surroundings, would not any other disease prove equally and as certainly fatal? While it is a fact that the most fearful suffering and death follow the bite of certain animals, whether mad or not, yet, in my judgment, there is no disease *ab initio* entitled to the name of rabies, *except* this form of panic. This panic may destroy life, as has been proven many times, negatively at least, by post-mortem examinations without any sort of anatomical lesions. This is freely admitted by the most enthusiastic advocates of the disease called rabies.

Only a short time ago I received from the author, Dr. Arthur E. Spohn, of Corpus Christi, Texas, an article on "Rabies and Anti-Rabic Inoculations." I need hardly say he is an enthusiastic advocate of the disease and Mr. Pasteur's cure. He says: "The disease is generally described as having three stages: Melancholy, irritation and paralysis."

Each stage has its peculiar symptoms. A person is bitten by a rabid animal; before the period of incubation of from 16 to 199 days has passed, if the patient is very nervous, we are liable to have emotional symptoms, or spurious rabies,

where the symptoms will simulate all accounts of hydrophobia he (the patient) ever read or heard of. I have known them to have attacks of intense melancholy commencing within a few hours of the injury. I believe many persons die from spurious rabies and, while in no way depending on a specific virus, if continued will run into melancholy, irritation and death. It is in such cases, and they are far the most frequent, where properly directed treatment will have a beneficial effect; while for the true rabies there is at present no known remedy, our only hope is in prevention.

"This period of incubation, or latent period, lasts from 16 to 199 days, an average of 48.73, which corresponds with the period given by Mr. Youatt of from 42 to 49 days. During this latent period the wound generally heals; the person returns to his ordinary avocation, still is not free from suffering, often becoming extremely nervous, restless and excitable—living in constant dread of the approaching results. It is this state of uncertainty which makes rabies such a terrible affection. On many occasions I have been consulted by persons months and even years after they had been bitten by supposed rabid animals, telling me that their lives were completely useless; living in constant dread of the horrible results. One man who was under my observation had been bitten by a wolf. For about a year and a half he suffered intensely, was not able to attend to business and died of paralysis. I have no doubt this man died from the result of the injury."

It will be observed that Dr. Spohn says there are two kinds of rabies, the real and the spurious, of which the latter is far more numerous. It will be further observed that he says the maximum time for incubation is 199 days, yet this man's death occurred 547½ days after he was bitten. The doctor says he has "no doubt this man died from the result of the injury," nor have I the least doubt of it, but it was 547½ days of panic which killed him not rabies. This was the anatomical injury, the pathological condition which caused his death.

Dr. E. C. Spitzka, of New York, who is an educated gentleman, and one who has had large experience in veterinary medicine, says he has never seen a case of true hydrophobia. In writing upon

"How We Can Prevent False Hydrophobia," he quotes the following from Pepper's System of Medicine by American Authors, the particular author quoted being a believer in the reality of hydrophobia. The quotation refers to cases of more than usual interest and I offer no apology for giving it at length.

"The languor and nervousness attendant in extreme heat tend not only to hasten the activity of any disease germs actually present in the system, but also strongly favor the increase of that nervous fear which so often generates a fatal pseudo-hydrophobia (lyssophobia) in persons that have been bitten by dogs.

The most difficult to distinguish from the general disease are those cases in which hydrophobia occurs as a disease of the imagination, the result of fear, the lyssophobia of the writers. In these there is always the history of a bite, the cicatrix even may have become the seat of congestion, redness, itching, or neuralgic pains and these, acting on a susceptible brain, develop a disease which is hardly distinguishable from true hydrophobia and which is quite as fatal if left to run its course. These cases have usually less reflex susceptibility than genuine hydrophobia; the attack mostly occurs shortly after some conversation on the subject, and especially about the effects of the bites on others, and the victim is seen to have been subject to hysteria or other nervous disorders. *At the same time the concentration of the mind on this subject sometimes produces even structural changes in the medulla*, and the reflex susceptibility in coördination with the other symptoms may be almost perfect. In a case reported a few years ago by Hammond, the symptoms appeared perfectly characteristic, and at the necropsy circumscribed points of congestion were found near the roots of the vagus; yet the dog that bit this man was said to be alive and well, and, in the absence of any successful inoculation from biter or bitten, the case must be presumed to have been lyssophobic.

Many cases with a more favorable issue are recorded. Bellenger had a patient who had been bitten by his cat and manifested violent paroxysms of hydrophobia, but was instantly cured by the sight of the animal in good health. Brownell records the case of a man that was bitten by his dog, which

afterwards disappeared. He was seized with severe hydrophobia which continued for two days; when the lost dog was found and presented to him the symptoms disappeared. Trousseau speaks of a magistrate whose hand had been bitten by his hound, which immediately after attacked a flock of sheep, so that many of them died from rabies. The master then manifested hydrophobia, but, as death was deferred beyond the usual time, he concluded it was not genuine and recovered. Professor Dick was called to visit a man who had been bitten by a favorite dog, which, while suffering from distemper, had manifested severe hydrophobic symptoms, and had been given up by the attending physicians. He succeeded in convincing the subject that as the dog had had distemper and as no two great diseases could exist in the same system, it could not have had rabies. In spite of the false premises this reasoning had the desired effect and the patient recovered. A few years ago a boy, 12 years old, in Ithaca, N. Y., was bitten by a dog supposed to be rabid and, in due time manifested hydrophobia, which advanced rapidly until he was having a violent paroxysm every half hour, and it was pronounced impossible for him to survive another day. At this time I saw him, observed that he had a nervous organization and was somewhat lacking in the hyperæsthesia of rabies. I learned that he had recently been gorging himself with Christmas delicacies and was very costive, and as there was no satisfactory history of the dog, I at once suspected lyssophobia. The friends and strangers who had come to condole with the parents and feast on the horror were excluded, and the boy's attention fully engaged in amusing pictures and conversation. The paroxysms were omitted and, in two hours, the patient overcome by weariness, went to sleep. Next morning he was still kept secluded and quiet, and two enthusiastic students took up the role of keeping his attention constantly engaged on whatever would interest him. The *prima via* was relieved by medicine, and under a course of tonics he quickly recruited, and at the end of the week went back to school."

Dr. Spitzka also relates the following: "A case occurred in this city a few weeks ago, which illustrates how a little good sense on the part of a physician may avert a calamity in the same manner so happily

effected by Professor Law. A boy of 12, had harnessed his own and another large dog to a boy's cart. The reins got entangled and the dogs quarrelled. The boy went to the assistance of his own dog and was snapped by the antagonist. He thought little of it; but the boys on the street told him he was doomed to die of hydrophobia. Some grown-up imbeciles—not inmates of a lunatic asylum, but fellow citizens entitled to vote—joined in this verdict, and the poor boy came home with his face as white as chalk, kissed his mother good bye and, saying he had to die, disposed of his little possession. The family physician was called in about 8 o'clock. Instead of pooh-poohing the matter which, though practicable, would not have effected his purpose so well, he said: 'Well, my boy, I see how it is, you are passing through a crisis. If you survive 9 o'clock this evening you are positively safe.' The child's attention was thus fixed upon the minute hand of the clock; after it had passed the critical point no more hydrophobia was heard of in that house."

Cases of the kind above described have induced the advocates of rabies to divide it into two kinds, true and false, or hydrophobia and lyssophobia. The only real distinctive features between the two being these: if the patient dies it is true hydrophobia, but if, by any means, the panic to the mind is allayed and the patient recovers, then it is beyond all doubt or question lyssophobia. All this seems to prove and confirm the assertion I made in the beginning that the disease is altogether the result of panic. I do not believe there is a well-established case on record, of the death of anyone from this so-called disease, where the mind of the patient has been fully and entirely relieved from the intense strain and pressure it always undergoes in such cases. See how many are cured, as they call it, by the application of mad stones. Scientific men know there is no intrinsic virtue in them, yet they allay the panic in the mind, and thus afford relief. Anything else affording relief to the mind would answer the same purpose.

I believe it is Green who, in his work on pathology, says: "If the habit and thought of the medical minds were more analytical and, if physicians would reason and draw conclusions logically, governing

their deductions by strict logical law, many changes would be made in the now accepted opinions of etiology and pathology." Let us endeavor to follow his advice. Let us seek truth for its own sake, and when we find it let us open the doors of our minds and receive it no matter how many old theories and popular fallacies it may drive out. In the language of the Bible, let us prove all things and "hold fast to that which is good."

It will be observed that the most zealous supporters of the theory of hydrophobia admit that people have suffered and died from false hydrophobia, and it is also admitted that a large majority of the cases are of this kind. Hence, it follows that the people have been so educated, and improperly edu-

cated that, before this so-called and pretended disease, they become panic stricken and die most terrible and excruciating deaths. Remove the great fear, the intense dread; in short, prevent or, at least, allay the panic and the disease will disappear like dew before the morning sun. The medical profession has contributed largely to the false education of the people on this subject. This being the case, is it not incumbent on us to use our best endeavors to correct this great, serious and fatal error? If we have in the past in any way contributed towards educating the people so that they become panic stricken and die, is it not our duty to now use our best endeavors to restore their calm reason; remove the panic, in short, educate them to live?

THE PRESENT STATUS OF URETHRAL SURGERY.

E. R. PALMER, M. D., LOUISVILLE, KY.

Otis published his first case of successful urethrotomy with the Otis instrument, in the *New York Medical Journal* in 1878, and it may be safely said that in about the year 1883 the craze of promiscuous internal urethrotomy struck this country. That Otis has done much good work, and has contributed some valuable and vital information to genito-urinary surgeons is beyond peradventure, but that the operation has been very much misused, and very much abused, and very widely and unwisely applied is also beyond peradventure. In June, 1890, I reported fourteen cases of successful internal urethrotomy for close stricture at the bulbo-membraneous junction, without perineal section. When Otis went abroad early in 1880, and advocated his operation on the principle that all gleet was dependent upon stricture, that all stricture could be cured by internal urethrotomy, I may say that the foreign surgeons almost without exception, opposed his doctrine; and notably the English, among them Mr. Harrison, who declared it was an unsafe, dangerous and unsurgical procedure to cut stricture of small calibre by internal urethrotomy, without at the same time

making a counter opening in the perineum so as to permit the escape of urine, and to prevent the danger of hemorrhage into the bladder.

As before stated, in 1890 I reported fourteen cases of urethrotomy for close stricture of the bulbo-membraneous juncture without external urethrotomy, without a single complication and with a permanent curative history. At the meeting of the State Society in June last, I reported twenty additional cases, unselected, of the same operation, with the same history. I have here copied from my case book for 1892, a list of fourteen more cases of operation for close stricture, in men who could not urinate except with the greatest difficulty, and in some cases could not urinate at all, where the catheter even could not be passed. Fourteen additional cases of urethrotomy without external urethrotomy, and in these fourteen a history of complete cure in every case.

At the meeting at Altoona, the opinion of nearly every one present was to the effect that Harrison's operation, namely, the operation through the perineum, should be done jointly with internal urethrotomy. Last June at the meeting in Richfield Springs, New York, Dr. Taylor made the

*Read before Medico-Chirurgical Society, Louisville, Jan. 20, 1893.

statement that he was entirely in accord with me in the belief that the operation for close stricture in the urethra could be safely done without perineal section, with as much assurance of permanent curative result, as if the operation advocated by Harrison, viz: the opening of the perineum into the membranous urethra—was done at the same time as the operation for internal stricture. So that I feel—with a report now of something in the neighborhood of fifty cases without a solitary case of hemorrhage into the bladder, without a solitary case of complication of any sort, and these unselected cases running anywhere from twenty-one to seventy-four years of age—that I am safe in claiming that there is no necessity for opening the perineum when it becomes evident to the surgeon that it is necessary to do an operation for close stricture of the urethra.

The most important thing about operations for stricture of the urethra is the proper classification of cases. It goes without saying that there are men here to-night who would continue to discuss until daylight as to the most desirable mode of treating urethral stricture, as between dilatation, or division, or section by the knife. Beyond any question a great many surgeons have very unwisely cut the urethras of men suffering with stricture, and beyond all question one of the results of unwise cutting of the urethra for stricture is impotence and a more or less permanent deformity of the penis during erection. Beyond any question the operation is being done too often and very unwisely by men who claim that all cases of unsymmetrical urethra or of gleet should receive the knife. I think it has never been emphasized as it should be, that the law of inverse ratio is nowhere more positively exemplified than it is in urethral stricture, namely that the worse the stricture the better the result. When I first began working in the matter of urethral stricture I cut nearly everything where there was any contraction or any irregularities that the bougie a boule would detect. I did not believe there was much virtue in the treatment by sound for permanent cure of stricture. Since then however I have changed my practice and never cut a stricture until it has been demonstrated that it cannot be cured by dilatation, or

until it has become an extreme case of close stricture. I now seldom cut a stricture of large calibre, but do cut all close calibre strictures and, as before stated, the worse the case the more certain and permanent the good result. Before showing one or two instruments I want to emphasize what I have just said by reporting two or three cases.

No. 1.—Bank clerk, came to me with impotence, with the statement that he had never had a proper erection in his life; that he had been under medicine, and under urging in the way of becoming self confident, etc., attempted to demonstrate to himself his manhood. He had completely failed in this, and stated that he absolutely never had any venereal connection with any woman; that he had an abundance of opportunities in this direction, but had never been able to have a normal erection. I made an examination of his urethra, and about 1½ inches back I found a stricture that almost completely obstructed the passage. I was able after repeated attempts to introduce a very small bougie. After making a careful examination, I made the diagnosis of mechanical obstruction that I believed prevented the inflation of the blood vessels or the glans, and while I was not convinced that it was a stricture properly speaking, still I believed that there might be a cure in this case by the splitting of this obstruction. So I, with much difficulty, passed an Otis instrument, believing that the necessity of the case demanded it. After splitting the obstruction freely, I was able to pass a No. 32 curved sound without any difficulty, and afterward passed a No. 32 straight sound. This operation was done three or four months ago, and he reports to me now that he can not only command an erection, but has also had satisfactory sexual congress. He is a very intelligent, rather intellectual, well developed young man, who has reached his twenty-sixth or twenty-eighth year, and had this trouble, which was probably due not to stricture, but to a neoplasm in the urethra. Of course the question of removing it by other means as a better surgical procedure, is one of considerable importance.

No. 2.—Some time ago a man came to me from an interior town, with a perineal fistula the result of a perineal operation for stricture of the urethra. The stricture which still existed, was promptly cut with

the Otis instrument, and as there was considerable shock following the operation, I gave the patient a drink of whiskey; he said to me "Doctor, you do not realize what you have done," and I replied that I realized I had cured him of a very serious trouble, as I believed that the fistula would close. He then remarked that he never took one drink of liquor without getting on a big spree. I told him that he would not get on a spree in this instance, and to be sure that he did not I took him to the train and saw him safely off toward home. He stopped at Lexington and went on a drunk for about a month; however the fistula closed and I understand he became entirely well.

No. 3.—Another case almost parallel with this as regards the nature of the stricture, was one that Drs. Roberts, Yandell and Rodman had been dilating for a year and perhaps more. The stricture could be dilated up to a 32 sound, and then in a very short time would contract again so close that it was almost absolutely impermeable. In this case the cutting operation was done without perineal section, and the man got well without any unfavorable symptoms at all.

No. 4.—The next case was one that Dr. Roberts also saw. A man who had a close stricture at about the bulbo-membraneous juncture, was taken down with a violent fever, and after recovering from the fever had a perineal abscess resulting in a permanent perineal fistula which some doctor in Indiana operated to close. When the patient came to me the perineum was gaping widely with some of the stitches still in situ. Two well marked strictures were found in the urethra, which were promptly cut, and the fistula closed, the patient getting entirely well without further operation.

No. 5.—A fire insurance man, aged 74 years, came to me stating that he had had stricture of the urethra for over fifty years. A prominent homeopathic physician in the city told him that he had an enlarged prostate. An examination showed that he had a perfectly normal prostate, but had eight strictures of the urethra, one right back of the other. A careful examination of the urine revealed no disease of the kidneys, and no abnormal condition except the strictures. The patient had to rise frequently during the night, urinating at all times with

extreme difficulty. The operation of urethrotomy was done without perineal section, and the man is now perfectly well. He is entirely cured with the exception that his expelling powers are not as great as they would be were he a younger man.

In regard to hemorrhage into the bladder in these cases, Keyes states if you have a clot in the bladder do not interfere with it. If there has been a clot in the bladder, or hemorrhage backward in any of the cases I have operated upon, I am not aware of it. I have simply reported these cases to prove, or to emphasize my firm belief that it is not necessary to put patients of this character in bed for two or three weeks, as will be the case if you open the perineum.

Now in the rapid progress of urethral surgery comes the question of the urethroscope. As the elder Otis was a firm advocate of the doctrine that all gleet was dependent upon stricture and all stricture called for the knife, so the younger Otis comes to the front with the most perfect urethroscope that has ever been devised. By means of it we are enabled to explore the urethral canal, and definitely locate any stricture or neoplasm, or any other conditions which may exist, that cannot be cured simply by internal urethrotomy. We all know what the experience has been in Louisville with the cystoscope; it has been previously expressed in this society that it is not the most reliable instrument in the world. I think, however, that the urethroscope will come into quite general use; without mentioning any names I may say that three or four of the prominent young men in this city, have been recently entirely cured of persistent urethral trouble by its means. By its use the exact location of the ulcer or inflammation can be determined, and the proper solution can be applied directly to that point. I think this fully demonstrates the fact that the improved Otis instrument is of value, not only in stricture, but in other conditions which we find in the urethra equally as serious as stricture.

She—Professor, did you ever read Martin Luther's commentary on the "Diet of Worms?"

The Professor—No, I have not. I am a strict vegetarian, you know.

SOCIETY REPORTS.

THE MEDICO-CHIRURGICAL SOCIETY, OF LOUISVILLE.

Stated Meeting, January 20th, 1893.

THE PRESIDENT, Dr. F. C. Simpson, in the Chair.

OVARIAN TUMOR.

DR. A. M. VANCE: The specimen I exhibit here is an ovarian polycyst and the other ovary removed from a maiden lady forty-two years old. The only point of interest is that her attention was never called to the tumor. It was discovered by her physician who was called on account of some pain during menstruation. The tumor contained a number of cysts and the cystic fluid was very thick. The whole operation was done in eighteen minutes.

BUBO.

DR. W. O. ROBERTS: Two years ago I saw a young man with a chancroid on the penis, which was followed by a bubo in the right groin, which, of course, went on to suppuration and was lanced. There was no further trouble until two weeks ago. Then he came to my office with an enlargement in the groin, which he said came on after pretty hard work at the store, in which he had done some heavy lifting; that he had felt some pain in the groin and that in a short time it began to swell. When he came to my office the enlargement was about the size of the first joint of my thumb, and quite tender. I put on a compress and bandage which he wore for ten days; but instead of improving the swelling continued to increase and, finally, I made a free incision into it and a considerable amount of pus escaped. The incision was very long—over two inches, and the suppuration seemed to be from around the gland instead of from the gland itself. I then put on an antiseptic poultice and bandage, continuing this treatment for three or four days; the gland seemed to increase in size and all the time the suppuration continued to come from around it, and I thought possibly I had not gotten into the gland. I then held it with a pair of forceps and cut through the centre, but no pus came away. I then put the patient under chloroform and removed the entire

gland. I exhibit it here for your inspection; it is now very much shrunken from being in alcohol; it was dissected out with my fingers, leaving a very large cavity.

DISCUSSION.

DR. E. R. PALMER: I have read, in the last few days, a paper from one who wrote as if he thought he had discovered the only way to treat bubo with all its complications; and the only point he makes of any particular value, is that peri-adenitis is often antecedent to suppuration of the gland itself; and he advocates, instead of early opening, the very latest opening possible in order to allow of full destruction not only of the gland but of the connective tissue about it. And then he favors the trimming off, under chloroform, of the entire roof. This is the old operation and leaves a broad, wide and open ulcer which you can curette, clean and pack, treating so that it will be sure to granulate from the bottom, resulting as he says in a smooth and almost normal cicatrix.

We were promised a year ago by Dr. Francis Watson, of Boston, a paper on the treatment of bubo based upon his statements that the ideal treatment had never yet been formulated. But unfortunately he went abroad and the paper has never been read. And I must say, when it comes to making these enormous openings with a view to radical and speedy cure, that you leave the patient in such condition as will certainly cause him, throughout his entire after life, to conceal his person lest the exposure of this broad flat or depressed cicatrix will tell the story of his previous infection. I think it is a big question in treating these inguinal abscesses in young men, whether we shall give them a speedy cure by radical and rapid surgery that shall clean out everything, making a wide open sore, and leave them with a broad mark that will remain with them through life, or whether we should prolong the treatment for a few weeks, or perhaps several months, and finally get them well

with only the merest white line to mark the place where incision was made, the skin not having been removed, thus insuring in later life the precaution against exposure that may come. In treating young men for suppurating groins, we are bound to recognize a fact which we all know as doctors in middle life, that it is very important to have a man so that in later life he can throw off his clothes or go to sleep on a hot summer day with the possibility of his shirt getting above his groins, without exposing a great, broad, depressed cicatrix such as comes from these extensive operations. In my own work I am not afraid to do radical operations in the groins, and am perfectly willing to do them, but when a young man presents to me with glands of this sort, I nearly always procrastinate and work through small apertures, curetting through them, using peroxide and bichloride of mercury solutions, doing a great amount of hard, tedious work, extending over quite a period of time, with the simple idea that a few weeks or even a few months are nothing to a man if, in the end, he can be cured with such treatment and be in a presentable condition later on in life. Every married man, who has lived up to middle life, knows that a man is liable in his bath and in his domestic life to expose himself very generally, and I have seen cases where these glands were taken out, leaving a large scar which might have been avoided by proper treatment. Every one knows that by radical treatment in these cases, we are apt to get these big scars, and what is the best surgery from a purely surgical standpoint has not yet been fully determined to be the best practice. I am speaking largely not only with reference to the operation as performed by Dr. Roberts, but with reference to Dr. Rodman, both of whom operate extensively on the groin, and also with reference to the article which appeared in the journal mentioned. This man's idea is to simply first open and evacuate, then at the last moment making a large incision and with scissors trim off and take out the entire roof and make a large open sore that can be curetted, cleaned, disinfected and treated, with a resulting cicatrix which comes, of course, in a short period of time; this usually leaves a pale, hairless, depressed cicatrix which we ought to try and avoid in young men who have thirty or forty years

of married life coming to them afterward.

DR. C. SKINNER: What per cent. of buboes suppurate in your experience?

DR. E. R. PALMER: Syphilitic bubo almost never suppurates; gonorrhoeal do sometimes and virulent buboes always. I have had patients where there was a patch as large as a dollar, of blue tissue which could be lifted up, and that you could get under with your curette or with your probe. Under this treatment advocated by the writer in the journal referred to, the operator would take a pair of scissors and trim off this entire flap with the view of getting an exposed ulcer which can be cleansed, disinfected and curetted. His idea being that the under surface of this diseased skin is filled with material that contains the bacteria of suppuration, which will keep infecting the tissues underneath. But I believe that this flap can be cleansed, and better results and less scar obtained by not trimming off the roof. By reversing your curette you can clean the entire under surface of the skin. I have done this in several instances until the skin was as thin almost as linen cloth. You can curette in this way and then cleanse by frequent washes of peroxide of hydrogen, followed with bichloride of mercury, then by a carefully adjusted compress with spica bandage, you can preserve this piece of skin and the wound will heal leaving only a very small cicatrix which cannot be discovered without close inspection. So far as the surgical treatment is concerned, it is a very easy matter to make a counter-opening, if necessary, and insert a drainage tube. I have sometimes found it necessary to do this. Frequently in cases that have previously had suppurating bubo, you will find ridges of considerable size left. It has been my experience that these ridges under constitutional treatment, under cod liver oil, under hydriodic acid and under a properly adjusted compress, can be gotten rid of. I believe that the treatment of this condition is a question that will be very largely discussed in the future.

DR. A. M. VANCE: Do you mean this talk to apply to glands where suppuration has already occurred before being seen by you?

DR. E. R. PALMER: Yes, of course. I see comparatively few suppurating glands. It is perhaps remarkable that I see so few of them. A great many of the cases that apply to me have passed through the hands of other men.

DR. A. M. VANCE: In cases of chancroidal bubo without suppuration, do you practice prophylactic treatment of the gland?

DR. E. R. PALMER: In chancroidal bubo I do not believe with the extirpation of the gland you can hope to remove all the infection. I believe that the lymphatics are involved to such extent that the enucleation of one enlarged gland will hardly remove the source of infection. In addition to the enlarged and infected gland there is, in nearly all cases, a peri-adenitis below and around the gland itself.

DR. W. L. RODMAN: I take issue entirely with Dr. Palmer as to the question of scarring. I think the bad scars he has seen must have been caused by the very practice he advocates. It is only very recently, and by a few surgeons, that these glands have been dissected out bodily. I think that the operation should be done not only to save time and get the man out as soon as you can, but for the very purpose of preventing scarring. If the operation is carefully done the scar left is so small as to be scarcely noticeable. I recalled three or four cases, while Dr. Palmer was speaking, upon which I have operated for enlarged glands (and I would like to have had the patients here to-night) where the wound was closed by deep as well as superficial sutures, and where union took place by first intention. In one case I found that suppuration had already taken place in the gland; it was carefully dissected out bodily, without infecting the wound which healed by first intention, and today I doubt if a scar could be seen. I operated upon a man at the city hospital, who had enormous glands in the groin, and there was union by first intention in the same way. The resident physician, Dr. Tomlin, operated upon the other side shortly afterward, the wound healing by first intention. In this case I doubt if today you can see a scar on either side. I would operate for the purpose of preventing scarring. The majority of these cases will go on to suppuration, and we cannot prevent scarring if we allow the tissues to break down themselves. If the glands are dissected out carefully and deep sutures inserted, there will be no trouble at all, and you will have no depressed cicatrix as you will have should they discharge spontaneously. I think every gentleman here will agree that where you find enlarged glands on the neck or face, and you are

satisfied that they are going to break down, it would be very much better to make a small incision and dissect them out, in order to prevent suppuration and the formation of ugly, depressed cicatrices we so commonly see in patients treated by poultices and other expectant means.

DR. E. R. PALMER: I suppose all men have curious experiences and, simply to emphasize that, I am going to say that I am treating a very large number of cases of gonorrhœa seven days in the week, and I do not think I can recollect, in eight years' practice, five cases of suppurative glands from gonorrhœa that have opened. I have had some pretty large glands in gonorrhœa that have eventually disappeared. I believe these very glands Dr. Rodman has opened and found pus in, had they been subjected to less radical treatment, would have disappeared.

I have a case under treatment now, a young man who had some femoral glands enlarged from gonorrhœa, that a doctor in the city, one of the regular members of the profession, diagnosed as rupture and applied a truss for its relief. When the patient came to my office there were two or three openings leading up to a broad extensive sinus; the overlying tissues were very much diseased and blue in color; there was also a counter-opening communicating with this sinus that had been formed by the truss. In this case we removed the truss, dilated and curetted the infected portion of the tissues, injecting peroxide of hydrogen then bichloride of mercury and treated it with antiseptic agents. The patient is doing well, and I think will finally recover without any scar. I do not, in my work, see one case in a thousand where there are suppurating glands from gonorrhœa that need evacuation.

DR. A. M. CARTLEDGE: What do you consider the pathology of gonorrhœal bubo?

DR. E. R. PALMER: You know the statement that Bumm made in regard to the child that died—that the cord was invaded by the gonococcus and that the gonorrhœa had followed the cord up. I do not exactly agree with Bumm concerning the pathology. I believe that bubo is caused by the germ of suppuration—at any rate I do not think the gonococcus does it. It must be the pyogenes—must be the pus bacterium that produces it.

DR. A. M. CARTLEDGE: You believe then, that suppuration which takes place

in the inguinal glands in gonorrhœa, is produced by the pus-forming micro-organisms?

DR. E. R. PALMER: Yes. I do not think it is always necessary or advisable to open these enlarged glands, but by pressure and careful management you can reduce them without extirpation. I know it is very tempting, and it is a beautiful operation to go down into the groin and dissect out these glands, cleaning them out thoroughly, carefully stitching the wound, and allowing the patient to get out in a comparatively short time, but it has been my experience that, by this treatment, there will be more or less scar left as a result, which could be prevented by the treatment I have suggested. I have seen a great many cases of so-called tuberculous enlarged inguinal glands and believe they should be at first subjected to the same treatment.

I want to stand fairly and squarely as an advocate of conservatism in the treatment of enlarged glands. I have never yet seen a case of enlarged glands from gonorrhœa that needed extirpation.

DR. C. SKINNER: I desire to say that I want to stand just as fairly and squarely on the other side of the fence in regard to the treatment of bubo. I think the only plan is to enucleate these buboes as soon as they show any tendency whatever to suppurate or break down. I have been doing this now for some little time—promptly enucleating the enlarged glands at the first appearance of suppuration.

In regard to the scar, I want to mention one case to show the effect of an operation for removing a scar, and at the same time removing a suppurating gland. Some time ago a young lady came to me with a swelling on her neck, who in childhood had had a suppurating gland of the neck which had been opened leaving a very ugly scar and one so deep that she had great trouble in keeping it clean. This swelling occurred near the old scar. I told her that I believed the only thing to do was to make an incision, removing the suppurating gland and at the same time take away this troublesome scar. I did the operation, carefully removing the gland and the old cicatrix. The wound healed perfectly, leaving, at first, only a small line. This was several months ago, and to-day not the slightest scar can be seen.

DR. A. M. CARTLEDGE: First of all, I think it is impossible to treat all of these

cases alike. We are all familiar with the different clinical characteristics of gonorrhœal bubo. Where I find surgical treatment necessary I have been in the habit of pinching these usually small abscesses up between my fingers and slitting them open. I do not see the necessity for making a large incision in gonorrhœal buboes, and I think they will get well better without it. I seldom make a larger incision than half inch. They are not especially infective, and with this small incision they get well without any perceptible scar. I believe the tendency to scarring is greater with a large incision, removing the gland. In regard to chancroidal and true virulent bubo, I believe I would agree with both sides and yet disagree with both sides in the discussion. I believe if the bubo has attained a considerable size, and you can demonstrate the existence of pus, it should be opened and the pus evacuated. But in doing this in a virulent bubo the wound is liable to become infected and thus prevent its healing. In such cases it may become necessary to remove the diseased glands.

DR. O. W. ROBERTS: There are certain conditions of the glands of the groin that we know will go on to suppuration. Chancroidal bubo is one of them. Another is the tuberculous gland when it becomes very much enlarged. I believe with Dr. Rodman that the thing to do is to take them out and to do the operation before suppuration has taken place. If this is done we are almost certain to get primary union. Even if suppuration has taken place and you can remove the gland without infecting the wound with the pus microbe, you are almost sure to get union by first intention and there will be little or no scar. There are other conditions which give rise to these enlarged glands in the groin in which the inflammation can be relieved by properly applied bandage and pressure and which will not suppurate. My experience with gonorrhœal bubo is, if I see a case early and can have the patient wear a compress bandage that they do not suppurate. Where they are allowed to go on without treatment for a week or so, and the patient is "on the go" all the time, they generally suppurate. I rather believe that these gonorrhœal buboes are the result of simple irritation and not caused by the absorption of the pus microbe.

In regard to the opening of these en-

larged glands, I do not agree with Dr. Palmer or with Dr. Cartledge that a small incision is all that is necessary. My experience is that much better results can

be obtained by making a free incision and removing all the enlarged glands than by simply making a small incision and trusting to peroxide of hydrogen injections.

CORRESPONDENCE.

THE COUNTRY PHYSICIAN.

MR. EDITOR:—

The country doctor is a species of humanity *sui generis*; he is usually born in the country, and frequently begins to practice in the town of his birth. On this account, all other things being equal, he has almost innumerable difficulties to surmount. First, his youth is a serious objection; then his want of experience; and consequently the utter lack of popular confidence.

Time, however, soon makes him older, although he usually assumes all of the characteristics of age at once—raises a full beard and is sure to give his birthday at its extreme cycle of time. Time also brings him patients, and consequently the necessary amount of experience, and the first two objections being removed, he *develops* popular confidence. Now his troubles begin. At first the beauty of the study of medicine fascinated him, then the philanthropic desire to cure all disease was his daily and nightly ambition. But later, when the first glamor has disappeared and he finds that sickness brings out the very worst side of human nature, he clearly realizes the fact that his profession is after all only a means of gaining "bread and butter," and he settles down to hard, steady and weary work for life, or at the very least, for the best of his days.

From his constant intercourse with sickness and death, he soon becomes half philosopher and half fatalist; believing only that which he can clearly see; loth to accept the theory of any one upon any subject until he has an opportunity to verify it either medically, mathematically or by the conviction of his own conscience. Now here is one very palpable reason why so many country physicians never see the necessity of connecting themselves with a church organization; it is surely not be-

cause they are not as moral as their fellow-men, neither because they are not "good material," but from the very practice of their profession they are liable, too frequently, to lose faith in humanity, and are thus strongly tempted to doubt the goodness of God.

The country doctor is by no means a follower of Diogenes—the tenets of his profession teach him differently. His knowledge of anatomy alone, should be a firm and sure foundation for a belief in the existence of Deity, and he usually endeavors to follow the golden rule.

In regard to sympathy, let me say there is no class of men who have more real, genuine sympathy for the sick and suffering than the country doctors; he has perhaps known his patients from childhood and many of them are his best friends; much sympathy is frequently hidden by a seemingly indifferent exterior, as it would not be proper to allow it to run away with the judgment.

The doctor, as a rule, never fully shows his true feelings in the sick room; his face is seldom an index of much sympathy; but there is always a warm corner in the heart of every honest M. D. for every sufferer.

The country doctor plods his weary way through the storm and mud of winter; jogs over the dusty roads in the heat of summer; faces the most severe storms for hours at a time; digs his way through snow drifts; reels off the miles over dark and lonely roads, while the farmer sleeps in his warm bed; eats his meals irregularly; has no day of rest, and but precious little time to call his own. I have often thought if the same time and energy was devoted to any other branch of business, a man would accumulate a fortune in five years.

It is almost a wonder that at the age of forty a man engaged in active practice in the country has even the shadow of a constitution, or the slightest resemblance of an anatomy left.

Here is a sample of one day's work: called up at four o'clock a. m. to "pull a tooth;" sees patients in his office until nine o'clock; then a horse is ordered and he starts on his rounds. First he visits a case of typhoid fever; then sees a number of children with scarlet fever or diphtheria; other calls are left for him at the neighbors, and no one knows when he will be able to return—perhaps at dark, to eat a cold dinner. Then another horse is brought to the door, and he hurriedly goes to attend an accident where all of his surgical knowledge and skill are brought into play; he retires at midnight, and before another day appears, he is up and out to attend upon an errand of mercy, as the result of which, the next census shows a new name on the township roll. He begins the day as a dentist, acts as physician and surgeon and closes it as an obstetrician—four branches of medicine in one day.

You may amuse the doctor, but you can never surprise him, and he will be the first to detect any exaggeration. The doctor is a king in his own locality, and is the trusted adviser of hundreds of families; more than mere friendship binds him to the hearts of his patients; "he hears confessions, and keeps them safe, as a sacred trust, like a righteous priest." If he does not receive his reward here below, he is surely entitled to a large share of consideration in another sphere.

The country doctor almost always has a good stock of hard common sense, and some of the brightest lights in the medical world have been born and reared in some little country town.

No one has a better knowledge of human nature in all of its varied characteristics than the village doctor; he has the opportunity of seeing his fellow men in a natural condition; when sickness comes, concealment and deception are cast aside, and poor humanity is seen without the gloss of fashion, policy or self interest.

There are people who have their Sunday face, Sunday actions, Sunday walk, Sunday clothes and some even have their Sunday religion. But when pain and death comes, how natural it is to throw off all dissembling and appear just as we really

are; it is then that we lose by comparison.

But humanity is not all satire. I have seen patients die in faith both the Protestant and the Catholic; have seen them meet death with a composure which surely indicated an abiding faith in God, and a belief that Heaven was better than earth.

To the rural practitioner is given an opportunity to enjoy and commune with nature; as he rides through wood and field in summer, he sees the various medicinal plants in bloom and recognizes them as old acquaintances; in the winter he enjoys the setting sun as it casts its shadows of red and blue over the artistically formed banks of snow which line the road, and extend far out in the wide spreading fields. During many a moonlight ride when the temperature was twenty degrees below zero, have I felt, as I dashed over the country in a sleigh, as though I owned the whole earth; the crisp air of a mid-winter night ride is truly exhilarating to both body and soul.

The city physician has a decided advantage over his country cousin. If there is a difficult case or an unusual operation, the city doctor has an abundance of assistants; but the country practitioner frequently performs many dangerous operations alone, or with some bystander as his assistant, and seeing one candle by the light of another. I have amputated the thigh at midnight, with only one miserably frightened girl to hold a lamp; have cut down upon a strangulated hernia without any one to even hold a light; have performed tracheotomy with only the mother of the child present to hold it upon her lap; have delivered women, tied the cord with a string from the window shade, cut it with my pen knife, and washed and dressed the infant—thus acting the part of both doctor and nurse.

The country physician is often obliged to fight disease single handed, when the city doctor has the satisfaction of verifying the aphorism, "in the multitude is safety."

All honor to my brother country doctors! They are indeed indispensable. And fortunate are they if, after having endeavored to be true to their profession themselves, it may be happily said of them

"A life well spent whose early care it was,
His riper years should not upbraid his green;
By unperceived degrees he wears away,
Yet, like the sun, seems larger at his setting."

JOHN C. HOLMES, M. D.
Cranbury, N. J.

THAT UNFORTUNATE "CONSERVATIVE."

EDITOR MED. AND SURG. REPORTER:

I am far from any desire to raise a controversy in your journal. Such a course would not be of benefit to the profession, to your journal, or to myself. However, I think I am entitled to note the criticism of Dr. Burr, in *THE REPORTER* for February 18th, entitled "The Advance Guard." It is a quiet, gentlemanly, sarcastic slap at my article in the *REPORTER* of Dec. 24, 1892, "The Conservative."

I think if the Doctor will look that article over again, he will fail to find a single line that intimates that the competent surgeon, of this or any other country, either specialist or general, is not entitled to all praise and commendation. I think he will fail to find a single objection to *any operation* when necessary. If carefully read it shows, I think, that it is the thinking conservative who makes the most brilliant advances.

Instead of quoting part of Webster's definition—(which he does) given in my article, let him keep all of it in mind. Particularly this—"one who preserves from ruin, injury; a preserver, a conservator." There is not a *good* surgeon but who does claim that his operation is called for by that definition. There is not a *good* physician but bases his treatment on that same definition.

That is what they are *here for*, and hence, according to Webster, all good doctors are conservatives.

But there is another class who are eternally whacking at the conservative as,—as I said,—"*a chump, a back number, etc.*" Waiting one day on a long, slow confinement with no particular features about it, I put in the time reading in a journal one of these shots. Then and there, I wrote the article in what I fondly dreamed was a 'serio-comic' vein. Well! I am either lost on the 'serio-comic,' or my critic Dr. Burr, can't locate the vein.

He quotes from my article this, "the conservative is the fellow who wants to know before he acts." Then adds this—"To reach which point of vantage, one must indeed be a very Solon or phenomenon of learning, or else manifest a large part of his time, a position of imposing masterly inactivity." Now after that, will the Doctor kindly pick up his MEDICAL AND

SURGICAL REPORTER of December 31st, and on page 1035, read this from Dr. Jos. Price's article, viz.: "To the inquiry 'who should do abdominal work?' there can be but one answer—the one who has served an *apprenticeship* and *who knows where, when and how.*" Now again, will the Doctor please glance down his own article and read what he, approving, quotes from "Our Philadelphia confrere," viz.: "It is not so much a ponderous dignity and sick room air that we need, but to *know what to do, when to do it and how to do it;*" and then ask himself if there is *any difference* between himself, Dr. Price and my poor "conservative" who wants to know before he acts." Fact is most of us "want to know" sometimes, more than we can ever know, viz., the certain result of executing what we do know.

Again the Doctor quotes disapprovingly "The conservative is the man who has seen many (old) theories die out, etc., new theories wither, etc." Well! that's perfectly true, not only as regards medical science, but every other science. Fact is, that statement is very commonplace and has nothing startling about it.

The Doctor says "Medical science originally was a system of baseless theories, bolstered up with spacious reasoning and unintelligible vocabulary." If my critic was an "original" Homeopath, one could possibly understand that position. I think, however, that ever since "Medical Science" could be called a science, the theories of the day were not baseless to the practitioner of the time. Baseless to us possibly, but he was as good as his day and generation and as true to his art, according to his light, as we are.

He erred from lack of a then impossible knowledge, and we learn from his mistakes as we do from our own; and yet,—Glory to his memory! Many of his theories and reasonings still abide with us, to bless and comfort us.

I quote from the annual address of Dr. Clark, president of the Boston Gynecological Society: "In certain cases of sudden occurrence of injury Hippocrates admitted that the spine might be rectified; he rather praises the principle, though he says succussion was chiefly practiced by those physicians who seek to astonish the

mob. To such persons, he says, these practices appear wonderful; people always extol such practices and never give themselves any concern as to the final results." From this it would appear that the old medical saint had been after the 'Radicals' in his day.

My friend writes—"The day is at hand, and even now is, when in place of that, we shall have an *exact science* (italics mine) and an intelligible reason for all things."

At this point I shall have to turn our friend over to you, Mr. Editor, for, on

page 823, REPORTER of Nov. 19, you say—"Medicine has not reached the point of an *exact science*, and never will," and I am afraid you are a true prophet.

Dear Dr. Burr—"Shake!" It was all meant for the best, and largely in fun. "The Advance Guard" kept right along after reading it, or possibly took the "Conservative" along for company, and not one of them ever dreamed of accusing me of stabbing *him* under the fifth rib. "Shake" again. Very truly,

S. S. TOWLER, M. D.

Marienville, Pa.

NEW YORK LETTER.*

At his weekly clinical lecture in Bellevue Hospital a few days ago, Prof. Samuel Alexander exhibited a young man who had a primary syphilitic lesion on his penis. The eruption had not yet appeared, hence the only treatment that was prescribed was an antiseptic solution with which to keep the parts clean, and calomel to be dusted on the sore twice a day. Although it was a typical chancre appearing three weeks after intercourse, with its indurated borders and enlarged inguinal glands, no antisymphilitic treatment was given, the professor claiming that it is impossible to positively diagnose syphilis previous to the appearance of the eruption.

In regard to the modern fad for checking syphilis by excising the chancre as soon as it appears, which is extensively practiced in Europe, Dr. Alexander made some rather forcible remarks. He said that, as it is impossible to conclusively diagnose syphilis previous to the breaking out of the eruption, doubtless the brilliant results reported by those genito-urinary surgeons who practiced extirpation, were due to an error in the diagnosis. Although 'tis claimed by many that syphilis is early a local disease, and that by removal of the primary focus the subsequent constitutional disease will be avoided, 'tis not true, for syphilis is a constitutional disease from the first. A reference was made to the case of Barclay Hill, in London; a man came to the

doctor two hours after an intercourse in which he lacerated the frænum; he ascertained before leaving the woman that she had syphilis. Barclay Hill washed the wound with an antiseptic solution and thoroughly cauterized it with nitrate of silver; the patient went on his way rejoicing, suffering only from the effects of the caustic. But in three weeks a luxuriant syphilitic eruption appeared.

Dr. Alexander has excised a great many chancres and at a time when all was favorable, the operation having been done early, previous to any inguinal enlargement and with a healthy zone of tissue around the sore, and in no case has he succeeded in preventing the constitutional syphilis.

The operation is justifiable in the case of a married man if the sore is outside on the prepuce and has a healthy zone of tissue around it. He is thus protected from infecting his wife, but the constitutional symptoms will appear as if no excision had been done.

At an autopsy in the morgue, recently held on the patient who was supposed to have tuberculous pleurisy, there was found to be a multiple endothelioma in the pleura. During his illness the patient had been tapped eighteen times and at each operation from one to three quarts of bloody fluid was withdrawn from the pleural cavity. The hemorrhagic nature of the fluid suggested either tuberculosis or cancer.

There is but little known of the en-

*Special Correspondent to THE MEDICAL AND SURGICAL REPORTER.

dotheliomata and but few cases of it have been reported. There is no mention of it made in text-books on pathology. These neoplasms seem to occupy the borderland between sarcoma and carcinoma. Their habitat is in the serous membranes. When found in the arachnoid their structure is that of the sarcomata, and when in the pleura nests of cells are surrounded by fibrous stroma, thus resembling carcinomata.

In the pleura of the patient mentioned above, a large number of firm, white, nodular masses were found, the pleura between the tumorous growths being nearly an inch thick. They had been of rapid growth, and seemed to partake of the nature of an inflammatory growth more than that of a neoplasm. The pleura of the affected part, as well as the growths themselves, cut like gristle, and from the cut surface a colloid fluid resembling blood exuded. The cells were large and flattened, resembling endothelial cells.

This form of tumor is very malignant and, attacking, as it does, the tunica vaginalis, peritoneum and other serous membranes, is difficult to diagnose or to treat. No doubt this difficulty of diagnosis accounts for the very few cases that have been reported. As more is learned about this form of tumor it will take a prominent place among the malignant growths with which we so frequently come in contact.

At a recent meeting of the Section on Surgery at the Academy of Medicine, Professor W. B. Coley read a paper and presented photographs and patients illustrative of the success obtained in the treatment of malignant growths by inoculating the patients with the virus of erysipelas. He had been actuated to test this method of treatment by observing a patient, who had been operated upon several times for the removal of a cancer which returned after each operation, gaining perfect recovery after having accidentally contracted erysipelas. This was seven years ago and there has been no return of the tumor. The next patient in whom he had tried the treatment was a man with a large sarcoma of the neck which had been operated upon without success. Dr. Coley injected erysipelas buoillon-cultures into the tumor a couple of times; it soon wasted away and there

has been no return. He has studied this method of treatment in thirty-four cases, seventeen of which had carcinoma and the remainder sarcoma. Three of the cases of carcinoma and seven of the sarcoma permanently recovered. Of the remainder all showed marked improvement except one who died accidentally, and another who died as a result of the erysipelas.

Dr. Coley explained the good results obtained as due to an antagonistic bacteriological action, and that its effects were constitutional, as growths in parts distant from the place where the virus was injected disappeared.

In the discussion which followed Dr. Bull said that he could confirm the report of the case presented by Dr. Coley. He thought, however, that this plan of treatment had its dangers and was far from perfect, but that it might prove a valuable adjunct to surgical procedure.

Dr. Daniel Lewis thought that erysipelas acted by its local irritative and destructive effects, the same as preparations of arsenic and other caustics; and that the efficacy of this plan of treatment should be more extensively tested before it could be generally adopted.

Dr. John A. Wyeth thought that the specific germ of erysipelas might have a peculiar influence on malignant growths, but that other kinds of inflammatory action often effect a cure. He spoke of one of his patients who had a sarcoma of the abdominal wall which was too large to remove, in whom a complete cure was obtained by injecting arsenious acid into and around the growth. Microscopical examinations by prominent pathologists conclusively proved the tumor to be a true sarcoma. This was done seven years ago and there has been no return.

Dr. Coley concluded the discussion by saying that erysipelas could not effect its results by local irritative influence, as in one of his cases a malignant tumor in the vagina, far from the seat of injection, had been cured. As he had tested it in seventeen cases of inoperable sarcoma, and obtained seven cures, he thought the sooner the public knew of it the better.

HYDROCHLORATE of apomorphine is now said to be the agent responsible for all the ill-effects of the Keeley "bi-chloride of gold" cure.

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SATURDAY, MARCH 4TH, 1893.

EDITORIAL.

GYNECOLOGY AMONG THE INSANE FROM ANOTHER POINT OF VIEW.

Whatever motive may have inspired the action of the State Board of Public Charities to condemn and interdict in a most sensational and public manner, the use of surgical methods of relief among the inmates of the female department of the State Asylum at Norristown, the folly of its haste is daily becoming more apparent. Whether it was done to influence proposed legislative abridgment of its powers, or whether some unworthier animus impelled, does not particularly concern the present question, save that it goes far to show the desirability of abolishing the Board or, at least, limiting its duties to matters within its understanding—which is equivalent to abolition.

While to the general public the report furnished a passing sensation and an opportunity to add another to the long list of imaginary horrors and abuses practised by the medical profession upon defenseless subjects, to the Profession it offered several questions of profound importance. The incident has been commented upon by many professional journals, generally from the point of view of the State Board,

and consequently with the same amount of information and judgment.

THE REPORTER has from the start sustained the action of the physician-in-charge in treating the patients as her best judgment, backed by the best opinions she could obtain, dictated.

THE REPORTER presents without further comment than its full endorsement, the reply of the Board of Trustees of the Norristown Asylum to the State Board of Public Charities. The reply, carrying with it a stinging rebuke to the meddling exercise of questionable authority, includes the report to the Trustees by Dr. Bennett, giving a full record of each case. Dr. Bennett's summary is the best presentation of the subject yet offered, and deserves the closest attention of the entire profession.

STATE HOSPITAL FOR THE INSANE,
S. E. District of Pa.

NORRISTOWN, February 3d, 1893.

*To the Board of Public Charities,
State of Pennsylvania.*

GENTLEMEN: At the first meeting of the Board of Trustees of this Hospital

after the receipt of your communication of December 10th, 1892, the Chief Physician of the Department for Women was directed to furnish a detailed report of the surgical operations alleged by you to have been performed in this Hospital for the cure of insanity.

We submit, herewith, her report upon six cases, the only operations of the kind ever performed in this Hospital.

You will see that, in this case, the operation was performed as the best judgment of the Medical Staff, to relieve suffering and to remove organs so much diseased as to no longer perform their functions; the question of sanity or insanity not being considered, insanity being regarded as a symptom and not a disease.

This Board has exercised great care and deliberation in the selection of its Medical Staff and, on purely medical matters, it does not profess to interfere with the judgment of the physicians in charge, believing that they have all the opportunities for judging correctly of the necessities of each case and the proper mode of relief.

If your committee will express to this Board its want of faith in either the skill or judgment of any of the Medical Staff, we shall give the matter immediate attention.

In connection with this matter, we would state that Dr. Morton, chairman of your Committee on Lunacy, was fully cognizant of the facts, as will be seen by the following letter from him to Dr. Bennett, congratulating her upon the success of one of the operations performed in July, 1892, which was long prior to your communication to this Board.

(Copy of Dr. Morton's Letter.)

DR. MORTON,

1421 CHESTNUT ST., PHILADELPHIA.

Dear Doctor:

I thank you for the opportunity for examining ——. She looks and seems perfectly well and I congratulate you upon the result.

Sincerely,
THOMAS G. MORTON.

DR. BENNETT.

We certainly think that, after such an indorsement, it is unfair for your Board, arbitrarily, without notice and without an investigation for each case, to charge that our work was experimental, and we know that the term used by your Board in calling these operations "Removal of Ovaries as a Cure for Insanity" was not warranted by the facts.

So far as the opinion of your legal member, Mr. Barlow, is concerned, being based upon wrong premises, it has no bearing upon the matter.

A careful examination of all the facts warrants the Board of Trustees in concluding that the operations were in the interests of humanity. The report of your Committee is evidently based upon a misapprehension of the facts, and we cannot withhold the expression of our regret that your Honorable Board has, without due investigation, not only judged and condemned our work, but that it has also thought proper to give wide publicity to a judgment based upon unwarranted assumptions.

We, therefore, respectfully ask that you will reconsider the resolution directed to this Board.

Very respectfully yours,

C. H. STINSON, GEORGE ROSS,
ELLWOOD M. CORSON W. D. H. SERRILL,
EDWIN G. MARTIN, JOSEPH THOMAS,
ISAAC ACKER, J. M. HACKETT,
WM. J. ELLIOTT, SAM. S. THOMPSON,
BARTON D. EVANS, JOHN T. DYER.

(Report presented to Board of Trustees,
Feb. 3, 1893.)

STATE HOSPITAL, DEPT. FOR WOMEN,
February 2d, 1893.

To the Board of Trustees.

GENTLEMEN: In obedience to your request, I beg leave to present the following condensed histories of the six cases in this department which have been the subjects of ovarian operations.

CASE 1.—Age, 49 years; American; married; mother of four children, of which the youngest is 18 years of age. The first attack of mania followed the birth of her first child, 29 years ago. The present attack is the fifth and came on about two months before her admission to the Hospital, May 24th, 1892.

Mental Condition: Mania of a mild type with delusions.

Physical Condition: General debility with anemia, small amount of albumen and mucous casts in the urine.

Internal Examination showed uterus retroflexed and drawn to left side. The attacks of insanity had always been preceded by periods of severe pain in the region of the left ovary.

Operations done July 3rd, 1892, by Dr. Marie B. Werner assisted by Dr. Joseph Price; there were present Dr. L. McMurtry, of Louisville, Kentucky; Drs. Kollock and McAllister, of Philadelphia; Drs. Bennett, Taber, Willits and Lothrop, of the Hospital Staff.

Both ovaries and tubes were removed by abdominal section.

Condition of Organs Removed: Left ovary and tube contained many small cystic tumors. Right ovary cirrhotic, with calcareous deposits; tuberculous degeneration of left tube.

Result: Patient recovered rapidly from the operation, and she went home completely restored in body and mind on the 6th of August, a little more than four weeks after the operation.

CASE 2.—Age, 28 years; American; white; single; apparent family predisposition to insanity. Patient had lived an irregular life, and was said to have suffered from internal trouble, dating from an abortion produced five years before. Admitted to Hospital, August 28th, 1888.

Mental Condition: Melancholia, with stupor, for the first year; for the following three years, lucid intervals, alternating with periods of violent maniacal excitement, during which she became profane, obscene, destructive and suicidal.

Physical Condition: General condition poor on admission; urine contained albumen and hyaline casts.

Internal Examination showed uterus prolapsed, enlarged and fixed; profuse secretion; masses felt in region of both ovaries, sensitive to pressure. Much localized pain suffered at times. No permanent improvement followed local treatment.

Operation done at same time with Case 1.

Ovaries and tubes on both sides removed by abdominal section.

Condition of Organs Removed: Hydrosalpinx of both sides. Adhesions of extraordinary firmness, roofing in the pelvis and binding tubes, ovaries and adjacent tissues in one mass, of which the parts were almost indistinguishable.

Result: Recovered rapidly and went home well physically and mentally, on the 17th of September, 1892.

Note: This patient was subsequently examined by Dr. Morton, who wrote to congratulate me upon the result.

The patient, herself, wrote October 12th: "I have not any of my old pain, and I think the operation I passed through has improved my health ten-fold. I feel as though I could not thank you enough for your kindness."

CASE 3.—Age, 24 years; married; admitted July 6th, 1892.

Eight months before admission, being then in the fourth month of pregnancy, she fell to the floor in convulsions, which lasted four hours; these were followed by some impairment of mind and occasional fits, premature delivery was induced two months later, without much benefit. From February to June she was in the "Friends' Asylum."

Mental Condition: Periods of maniacal excitement with delusions, alternating with longer intervals during which she was almost, if not entirely, well. Had five epileptic fits during the months of July, August and September.

Physical Condition: General condition fairly good.

Internal Examination showed right ovary prolapsed and enlarged; acute pain on pressure; mass felt on left side and in posterior cul-de-sac.

Operation done on October 13th, 1892, by Dr. Joseph Price, assisted by Dr. Willits and Dr. Bricker. There were present Drs. E. M. Corson, and S. N. Wiley, of Norristown; Drs. Bennett, Taber, Lothrop and Wilmarth, of the Hospital Staff.

Ovaries and tubes of both sides were removed by abdominal section.

Condition of Organs Removed: Both right and left ovaries contained numerous small cysts. Right ovary also contained a larger cyst, the size of a walnut.

Result: Rapid recovery from operation. No fits since October. Mental condition about as before.

CASE 4.—Age, 17; American; white; single; admitted April 12, 1892.

History not very definitely obtained, but mind probably affected for some months preceding. Father thinks that she was never the same after baptism by immersion, the preceding summer. She had left her home and otherwise acted peculiarly.

Mental Condition: Mania, with delusions; at times much excited and destructive, principal delusion that she was pregnant. Improved and went home, on trial, August 18th; returned September 16th, in a condition of stuporous melancholia; had to be carried into the ward in her father's arms; required to be fed and cared for like an infant; slight improvement during the following month.

Physical Condition: General condition poor; but improved under tonics. Urine contained traces of albumen.

Internal Examination: Uterus retroflexed and fixed. Excessive tenderness on both sides; regular local treatment produced little, if any effect. Menstruation painful and scanty.

Operation done at same time with Case 3.

Both ovaries and tubes removed by abdominal section.

Condition of Organs Removed: Ovaries cystic. Both ovaries and uterus in a singularly undeveloped condition, the former apparently devoid of ordinary ovarian tissue. It was the opinion of Dr. Price that these rudimentary organs could never have performed the functions pertaining to them, and it is reasonable to suppose that the periodic struggles of nature to perform functions, to which these undeveloped organs were inadequate, produced profound disturbance of the nervous system.

Result: Recovered promptly from the operation and went home well, physically and mentally, November 16th.

The change in this patient was very remarkable, and observed by all about her. Not only was there a marked improvement and development of her physical system, but, mentally and morally, there was a striking change for the better. Her father-writes January 25th: "If you would see her, and see how she helps about, you would think that she had never been sick." The patient, herself, writes February 1st: "Indeed I will never forget your kindness in getting me so well as I am, and thank you so much for what you have done for me."

CASE 5.—Age 36; American; white; married; had attack of mild melancholia, following the birth of her

first child, four years before, from which she recovered in this Hospital. Present attack came on one week after the birth of the second child. Admitted to the Hospital December 4th, 1888.

Mental Condition: Attacks of violent mania, alternating with about equal periods of a more quiet condition. The violence of maniacal attacks increased during the four years, until she came to be considered the most dangerous patient in our violent wards. The excited periods became a sort of frenzy; she was not only a wild, destructive and aggressive, but also very suicidal.

Physical Condition: General condition fairly good; urine at times contained albumen and casts.

Internal Examination: Laceration of cervix uteri, bilateral; left ovary acutely painful on pressure, and ligament on that side shortened. Subject to periodical, exhausting hemorrhages.

Operation done Oct. 23d, 1892, by Dr. Joseph Price assisted by Dr. Willits and Dr. Bricker. There were present Drs. E. M. Corson and S. N. Wiley, of Norristown; Dr. Katherine Kollock, of Philadelphia; Drs. Little and Mayo, of Minnesota; Dr. Parker, of Indiana; Dr. Jennings, of Virginia; and the entire Hospital Staff.

Ovaries and tubes of both sides were removed by abdominal section.

Condition of Organs Removed: Cystoma, the size of a hen's egg, in both right and left ovaries; ovaries otherwise cystic.

Result: Patient made a slow recovery from the operation, on account of suppuration around the stitches; transferred from the farm-cottage to ward, November 25th. Mental condition very greatly improved and [Feb. 2d.] still improving, has no violent attacks, takes an interest in all around her and helps constantly in the work of the ward; disposition amiable and seems happy. I think it possible that this patient may entirely recover, notwithstanding the long duration which is always an unfavorable element.

CASE 6.—Admitted to Hospital, September 9th, 1886. Age, on admission, 40; Irish; mother of seven children, of which the youngest was three months old; seven weeks after the birth of this child, became violently insane.

Mental Condition: On admission, melancholia, with periods of frenzy. With improved general health her mental condition also improved so that, for the last three years or more she was perfectly well, except during her periods of maniacal excitement which were coincident with the catamenia.

Physical Condition: On admission, generally poor, but improved under tonic treatment. Urine, at times, contained albumen and casts.

Internal Examination: Laceration of cervix uteri, bilateral; uterus not freely movable; thickening of left broad ligament and acute pain on pressure of left ovary.

Operation done at same time with Case 5.

Ovaries and tubes of both sides removed by abdominal section.

Condition of Organs Removed: Both ovaries cystic. Left ovary contained tumor the size of a walnut, which, in spite of the utmost care, ruptured during removal;

Dr. Price was of the opinion that this tumor was liable to rupture, and discharge its contents into the abdominal cavity, at any time during life, and that its presence was thus a constant menace to life itself.

Result: Patient died on the sixth day of peritonitis.

TO SUMMARIZE: Of six cases operated upon, three, or half the number, have perfectly recovered in body and mind. One is much improved. One is improved in some respects and not in others. One died.

It is of interest to note that five of the six, were of puerperal origin.

I want to emphasize the following facts:

(1) That cases were selected for operation only after thorough and searching examination, with consultation, often repeated.

(2) That each case selected for operation was the subject of serious bodily disease, such as may properly be, and habitually is, treated by surgical interference, quite apart from the insanity which is only an incident, or symptom, of such disease.

(3) That in every case of operation performed, the consent of the nearest relative, or guardian, of the patient was obtained.

(4) That no cases, other than those detailed above, have been at any time selected, or set apart, for operation.

Finally, I want to say that I believe that many cases now under our care, and others yet to come, might be saved from years of physical suffering, from hopeless dementia, even life itself might sometimes be saved, by appropriate surgical treatment. The study of Case 5, is to me inexpressibly sad. This unhappy woman should have been spared these four years of unspeakable suffering, and her complete restoration assured, by an earlier operation for the removal of organs diseased beyond the hope of recovery. I am conscious that my full duty toward her was not done.

In other and similar cases in the future I cannot reconcile it to my conscience to be merely a passive observer and recorder of their decline. If, in Pennsylvania, insanity is to be a barrier to the treatment of bodily diseases, it will be my duty to urge upon the guardians of these helpless ones, incapacitated for speaking on their own behalf, the necessity for taking their suffering charges, outside the state limits if need be, wherever they shall be free to receive the treatment adapted to their needs.

Very respectfully yours,

ALICE BENNETT.

TRANSLATIONS.

THE ABUSE OF MILK IN ALBUMINURICS.†

Lecorché and Talamon, (*La Médecine Moderne*, Jan. 14, 1893) dwell upon the abuse of milk in the management of albuminuria. According to them the treatment of albuminuria by the majority of physicians assumes a single and unchangeable form, namely, the milk diet. This forms in their minds a sort of algebraic formula, *albuminuria*=milk, the first term of which necessarily calls for the second. Every individual afflicted with albuminuria is, *à priori*, condemned by them to milk for the future. Without that no recovery and no treatment. They believe that they have done everything when, having found albumin in the urine, they prescribe without other procedures milk, only milk and always milk. True, milk is the medicine *par excellence* for nephritis, and its usefulness in albuminuria cannot be disputed. But it is a medicine which has its indications and its contra-indications as every other medicine, and it is as unreasonable to give milk to every individual who has albumin in his urine, as to prescribe digitalis to every person who presents a heart murmur.

The abuse of milk has for its basis the special idea emanating from the physiological axiom that milk is a perfect food. That milk is a food, and a perfect food, is granted, but the milk diet is not an alimentation. In other words, after the first infancy man is not constituted to live exclusively on milk. One liter of milk contains on an average 37 to 40 grammes of albuminoid material, 40 grammes of fat and 50 grammes of hydrocarbons. The daily ration of an adult being fixed at 125 or 130 grammes of nitrogenized principles, 100 grammes of fat and 300 grammes of hydrocarbons; it can be seen that if three liters of milk suffice to complete the sum of the nitrogenized and fatty principles, six will be necessary to furnish the sufficient quantity of hydrocarbons. In admitting that the considerably greater proportion of fat and albuminoids compensates for the deficit in the hydrocarbons, theoretically, there-

fore, four liters of milk daily should provide for the needs of the organism. What stomach is able to absorb indefinitely this quantity of milk without disgust and fatigue? Therefore, either the patient cannot take the necessary dose, or if he succeeds in obeying strictly the imposed prescriptions, the digestive tube revolts, and gastro-intestinal complications are produced. In two ways it tends to insufficient nutrition, general weakening and anemia. But to go further. Even suffering the daily dose to be tolerated and digested, is this dose actually equivalent to the ordinary ration of meat and vegetable foods? Milk debilitates. Look at a patient submitted for some time to an exclusive milk diet; his complexion is pale, his flesh is flabby, he is incapable of active cerebral work, and of all prolonged muscular effort. He has lost entirely his physical and moral energy. The chemical equilibrium is satisfied, but the vital equilibrium is not. Is it because the albumin of milk is different from the albumin provided by other nitrogenized materials? It is not known, but neither is it known why milk improves a vicious nutrition. This intimate action that is not known is without doubt the same in the two cases, favorable when the organism is surcharged with the products of an excessive fleshy alimentation, unfavorable when it is deprived for a long time of these same products. In fact, if the milk diet is a sufficient alimentation for a bedridden person, it is an insufficient alimentation for a healthy and active person. Now, three-fourths of the albuminurics are for months and years active patients whom we can have no reason for condemning to inaction. Therefore, when milk is prescribed for an albuminuric it is not as a food, but as a medicine and, therefore, as all drugs, its employment demands to be watched; given at the wrong time it may be useless or become dangerous.

In a general manner to order the milk diet in the period of remission of Bright's disease in albuminurics, who do not present other morbid conditions than the presence of albumin in the urine, when

†Translated for THE MEDICAL AND SURGICAL REPORTER, by W. A. N. Dorland, M. D.

the quantity of water is above the normal or even simply normal, when the solid constituents, urea, uric acid are in normal proportion, is unreasonable. If the hope is to cause the trace of albumin still shown by the urine to disappear it is vain. When the milk has quieted the acute irritation of the kidney, or re-established the circulatory activity of the organ when, by determining polyuria, it has prevented the dangers of accumulation in the blood of the principles which ought to be eliminated by the urinary secretions it has done all that it is able to do. If its usage is greatly prolonged the albuminuria cannot be made to disappear completely.

Surgery of the Biliary Passages.*

Dr. A. Fränkel made the following studies and observations during his service at the Rudolfinerhause, of Vienna. He first calls attention to the fact that it was Lauenstein, at the last Surgical Congress at Berlin, who first called attention to an apparently forgotten complication, i. e. adhesions at or around the region of the gall-bladder which frequently simulates biliary colic, and that the releasing of these adhesions will promote the cure. He cites two cases in which he assisted Prof. R. Gersuny, in which the previous histories had been exactly those of grave biliary colic, in which, however, no calculi were found, only various long bands of adhesions extending from the neighboring omentum to the region of the gall bladder. He emphasizes region of the gall-bladder since they found in each case a defect of the gall-bladder. One case was that of a colleague who had suffered for six years, from periodical attacks of colic, which presented the usual picture of that from gall-stones. There was but one symptom missing, namely, the retention of the gall in the gall-bladder which usually forms a palpable tumor at the border of the liver. A varying but not grave form of jaundice and a swelling of the liver of about three finger breadths was all that could be demonstrated by examination in both patients. Each case began with nausea and pain in the region of the stomach, extending later to the region of the liver. The attacks lasted usually from two to three hours,

extending themselves latterly from twelve to fourteen hours in the case of the colleague. The second patient gave a history of having had the attacks last from twelve to fourteen days, and stated that he frequently had seen in his stools masses looking like black sand which had been declared by the physician in attendance to be small gall-stones. In neither case was it possible to find in any of the canals, a stone, while in one there was but a band which seemed to originate in the normal position of the gall-bladder. The second patient possessed a thin walled, translucent and not enlarged gall-bladder whose lower extremity was tightly adherent to the omentum which ended in a band-like prolongation behind the liver. The operation consisted in separating these adhesions and drawing the peritoneum over the stump with silk sutures. The result was in both cases satisfactory. The patients are free from pain and enjoying perfect health. The author wishes to refer the reader to the practical and important points these cases present—that Cholelithiasis can be produced through the residue of previous inflammatory processes, and which may probably have its origin in gall-stone troubles, and also through diseased processes called forth from affections in the region of the gall-bladder. He thinks that in grave cases referring to the gall system, even though a strict diagnosis cannot be made, an exploratory operation might be of great use. There is a further lesson which these operations present, that of covering all stumps as much as possible with peritoneum in order to prevent any adhesive complications following. This was very clearly shown in an address to the Surgical Congress by Winiwarker who presented a case in which he had to perform repeated sections after an ovariectomy, in order to cure severe colics which had their origin from such bands of adhesions.—*Central f. chirurg.*, 1892.

Surgery of the Gall-Bladder.*

Dr. Carl Lauenstein, of Hamburg, says: At times the surgeon after making the incision finds the gall-bladder so contracted that it lies beneath the liver, making it impossible to see its outer margin. For such cases where it becomes necessary to

*Translated for THE MEDICAL AND SURGICAL REPORTER by Marie B. Werner, M. D.

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do the operation at one sitting, Riedel has proposed that the peritoneum should be loosened with or without the transverse fascia in the region of the abdominal wall, and its ends attached to the gall-bladder, forming in this way a funnel-shaped canal through which the contents of the gall-bladder can pass directly outward. This proposition of Riedel, which the author has been able to use in several instances is according to his views, of great importance in certain cases. He further states that among nineteen operative cases he found but two in which the contracted gall-bladder was so deeply situated that even following Riedel's method, it was impossible to prevent some of the gall or pus from entering the general cavity. In these cases the author found it useful to raise the large omentum over the transverse colon, drawing it at its free end to the gall-bladder, stitching it fast to its margins and in this way producing the canal for its safe passage. The author found in both cases a desirable result, which makes him feel it practicable to use the large omentum as plastic material for such purposes.—*Central. fur. Chirurg.*, 1893.

Three Cases of Cæsarean Section for Eclampsia.*

Wertheimer presents in his dissertation the importance of rapid delivery in antepartum eclampsia. In the early stages, however, while the os uteri is still closed and the cervix still intact, there has always been a difference of opinion. He feels he would follow the method of Halbertsma in particularly unfavorable cases of eclampsia in which immediate delivery is impossible, to produce relief by the Cæsarean section. He considers it necessary to study the number and intensity of the attacks, the gravity of the coma and the condition of the lungs, heart and kidneys, before deciding upon the latter mode of relief. He gives an account of three cases in which after careful application of all the above methods and a fruitless morphia narcosis, Cæsarean section was resorted to.

The immediate results in all three cases were good for both mother and child. In the first case, the mother succumbed to miliary tuberculosis after eleven days, and

in the third case, the eighth-month child died on the third day. In opposition to Löhlein and v. Herff, who present as first consideration the Cæsarean section for a living child, W. would still like to see this method practised in cases where the death of the child has taken place, but in which there is no change for the better in the mother. In the sixteen operative cases up to the present time, ten mothers were saved. In closing W. mentions Dührsen's method, which consists of a bloody dilatation of the cervix, respectively a combination of the bloody with the mechanical dilatation, the last with the aid of a Colpeuryter. The latter method, the author concludes, to be more dangerous than the Cæsarean section, while the first is without doubt void of danger.—*Wertheimer, Wiener klin. Wochen.*, 1892.

Some Observations upon Pathologico-Anatomical Changes in a Case of Tetanus Traumaticus.

T. Ventori, (*Central. f. Allgem. Pathology and path. Anatomy*, 1892.) In the case of a deceased man who had suffered from an injury to his right foot, after which followed tetanus, a pathological investigation showed the nerves of the hip intact but various degenerative changes in the lumbar region of the spinal cord, particularly at the roots of the spinal nerves which merge from the middle and lower portion of the lumbar enlargement. The columns of the spinal cord had met with but slight changes. Bonome found in two cases of traumatic tetanus the same conditions—the principal changes at one point or segment of the roots of the spinal nerves showing a strong line of demarkation, and which stood in some connection with the point of infection. In all other portions of the body the nervous system showed marked hyperæmia. Changes of lesser gravity in connection with the point of infection of the virus are also seen in the nerves and the segments of the spinal cord in cases of hydrophobia.

Ventori found in a case of hydrophobia, (following a bite in the right hand), a marked swelling of the throat and progressive degenerative changes in the spinal cord.

*Translated for THE MEDICAL AND SURGICAL REPORTER, by Marie B. Werner, M. D.

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ABSTRACTS.

RECURRENT EARACHE.

The necessity of finding the cause of recurrent earache which subsides without apparent injury to the ear. In writing on this subject Dr. Woods of Baltimore says:

No physician of considerable practice can have failed to have patients consult him on account of recurring earache. In some cases the pain comes in paroxysms of two or three hours' duration; disappears, sometimes spontaneously, sometimes only after the use of hot applications and anodynes; and returns after a long or short interval. Again, there are no distinct paroxysms of pain. The individual is conscious now and then that his ear hurts him. It never confines him to the house, and he may make only an incidental allusion to it when he happens to feel a pang, or thinks of the matter when with his physician. While by no means always so, the first class is usually made up of children, the second of adults. One will find, I think, that the subsequent histories of such cases divide them into three groups: (1) those who "outgrow," as it is called, the earache, or at any rate cease to have the attacks, and retain good hearing; (2) those who continue to have occasional paroxysms, or else now and then feel a twinge of pain, without the development of any special symptoms save a slight, and possible transient, defect in hearing; (3) those who after an attack of earache have a serous or purulent otorrhœa. This may subside and leave the ear still useful, but nevertheless impaired; or it may become chronic.

Thus earache may be a trivial matter. Again, it may be a symptom of an inflammation, which will soon show itself by a discharge; or else be the only appreciable indication of conditions which can cause slow changes in the ear and lessen its usefulness. If the diagnosis "earache" be looked upon as good and sufficient, and therapeutics be limited to relieving the patient's suffering, *possibly* no harm will be done; but in the majority of cases important things will be overlooked, and harm will result.

Barring furuncular and diffuse inflammation of the external auditory

canal, painful affections of the ear are due, usually, to catarrhal inflammation of the tympanic cavity, or to reflex neuralgia of the ear from some cause outside of the ear itself. Canal inflammation generally shows itself clear enough and need not be considered. Of catarrhal inflammation of the drum cavity, many cases pursue the typical course of hyperæmia of the tympanic mucosa, exudation into the drum cavity, perforation of the drumhead, and the establishment of an otorrhœa. Pain is the most prominent symptom of the stages of hyperæmia and exudation, and is relieved when the drumhead ruptures. But all cases do not go so far as perforation.

Tympanic hyperæmia may occur once or twice as the result of cold or exposure, and subside without serious results; but when it occurs again and again two things become manifest: (1) the usual results of repeated hyperæmia will probably ensue in the tympanic cavity, and (2) there must be some cause of these attacks more or less closely connected with the ear. That acute catarrh of the tympanum is the most common cause of the repeated earaches frequently observed in children, is the opinion of such authors as Woakes, Roosa and Buck; but the pain soon subsides, the hearing continues good, and nothing more is thought of the matter till the next attack. If more care were taken to make the tests, there is little doubt but that the hearing of ears which have passed through two or three such attacks would be found impaired. Still, as one can lose nearly one-half of the normal hearing power without being specially inconvenienced, the slow deterioration is not noticed for a long time.

Chronic abnormalities of the nasopharynx are a prolific cause to tympanic catarrh. Follicular pharyngitis, post-nasal vegetations and hypertrophied tonsils are, in my experience, the most common throat lesions observed in connection with recurring earache. It is, I think, a more or less common belief that, if chronic follicular pharyngitis does not cause so much throat discomfort as to call attention

to itself, or if post-nasal adenoid vegetations do not interfere with nasal respiration, these troubles may be left alone. That they can produce deafness and recurring hyperæmia of the tympanum without special throat or nasal symptoms, I do not think admits of doubt. Situated, as they often are, near the pharyngeal mouths of the Eustachian tubes, these inflamed follicles or vegetations act as irritants, increase the vascularity of the tubes, and cause an Eustachian catarrh. This can reach the tympanum by direct continuity of mucous membrane. Again, as soon as ventilation of the tympanum through the Eustachians is hindered, and the air already in the tympanum has been absorbed—no renewal taking place through the tubes—atmospheric pressure in the external canal drives the drumhead inwards, producing undue pressure upon the ossicles. Impairment of hearing and tinnitus usually follow at once. If unrelieved, hyperæmia and pain follow. Relief comes as soon as the Eustachians again admit air to the drums. Inflation by Politzer's method promptly removes the ear symptoms, and the application of a nitrate of silver solution to the mouths of the tubes lessens the secondary catarrh; but it will surely return, unless the primary trouble is removed. As regards enlarged tonsils, their importance from an otological standpoint has been exaggerated. Probably they rarely occur unaccompanied by other morbid conditions of the throat, which more immediately affect the ear. By lessening the air-space, they may, indeed, produce these conditions. This will certainly be the case if they interfere with nasal respiration. The same is true, however, of any conditions which block the nostrils. Mouth-breathing is a well-known cause of pharyngeal disease, and when nasal respiration is impeded in persons suffering from ear symptoms, it should be re-established. Still, so far as the *direct* influence of hypertrophied tonsils upon the ear is concerned, Roosa states that it is doubtful if they ever enlarge to the extent of pressing upon the mouths of the tubes. He advises their removal upon the grounds I have advanced: that they may "affect the health of the pharynx." I have seen patients cured of middle ear disease by the removal of post-nasal vegetations, although hypertrophied tonsils were also present. Another source of danger to the ears from

naso-pharyngeal disease is direct microbial invasion through the tubes. This undoubtedly occurs.

The teeth, and more particularly dentition, constitute a source of ear disease which is not sufficiently appreciated. The occurrence of otorrhœa in babies during dentition is frequently observed. Earache in infants, I am sure, is not always recognized as promptly as it should be. I see babies with otorrhœa whose clinical history is very clearly read backwards from the otorrhœa to dentition, but the pain the little one then had in the ear was not attributed to that organ.

Sexton, of New York, who has given the subject of oral irritation careful study, considers irritation from the mouth a most prolific cause of ear disease. He goes so far as to condemn amalgam fillings, vulcanite plates, and retention of teeth which have lost their nerve pulp, as dangerous to the integrity of the ears. I have tried to make some clinical observations upon this subject. While I have seen nothing to lead me to accept all Sexton says, I have over and over again seen earache, sometimes accompanied by hyperæmia of the drumhead and sometimes not, cured only after a carious tooth has been removed, or cleaned out and filled.

The channel of transmission from the teeth to the ears may be directly through the fibres of the fifth from the dental to the auriculo-temporal branch. This may be the case in those patients whose trouble is only *pain* of a reflex character, unaccompanied by inflammatory changes; but it will not explain the acute aural catarrh and suppurative otitis of dentition. Two explanations of these lesions are given: (1) extension of the inflammation from the gums to the middle ear by direct continuity of tissue. Roosa says he has seen this. Woakes, on the other hand, holds that the intermediate tissues are healthy, and offers, as an explanation of the tympanic catarrh, (2) vaso-motor disturbance.

Justifiable conclusions from the foregoing are, that the diagnosis in cases of recurrent earache must include the condition of the drumhead, pharynx, nose and teeth; that therapeutics must include the treatment of disease found in these structures.—*Maryland Med. Jour.*

Hahnemann's "Organon of Medicine" published the basis of homeopathy, 1810.

SURGICAL TREATMENT OF EPILEPSY.

Kümmell * reports ten cases, in which various operative measures were employed in the treatment of epilepsy, and reviews the various methods which have been suggested. He collects forty-five cases, where Alexander's operation of tying the vertebral arteries had been done. Eight of these gave distinctly good results; in eleven the condition improved; nineteen were not benefited, and in seventeen the result was unknown. To these, he reports two cases of his own in which the vertebrals were tied, first on one side and then on the other, but with only an extremely transitory result. In this operation the possibility has been suggested that all the fibres which pass from the superior ganglion of the sympathetic were cut off by the ligation, and hence Alexander himself has advised the removal of the superior cervical ganglion. This was done in one of Kümmell's cases, but here again the result was merely temporary, and after the operation of tying the vertebral and removing of the ganglion, the condition gradually grew worse. In four cases of epilepsy, where there was no history of previous trauma, and where the attack pointed to no special motor center in the cortex, he trephined over a tender spot in the skull. In these cases he found no perceptible changes at the point of trephining. The first two cases were materially improved; the second case was merely relieved of the tenderness; the fourth case, which presented more the features of petit mal, improved as to the psychical condition, although the attacks continued in a less severe form. Three cases presented distinct cortical epilepsy; in one, a portion of thickened dura was removed, and the patient had been for three and a half years without an attack; the second case presented spasm in the right arm and face, no physical changes were found in the brain except a possible projection in the inner portion of the skull; here no benefit was obtained, but the author regrets that a portion of the cortex was not also removed; a third case was of traumatic origin, and presented spasm in the right side of the face and the right arm; the thickened dura was removed, and the case has thus far continued well.

Gerster and Sachs † report ten cases of epilepsy where trephining was performed, seven of which were traumatic, one due to hereditary disease, one a case of infantile cerebral hemiplegia, and one a case of non-traumatic localized epilepsy, due to early acute brain disease; one case showed great improvement; three, slight improvement, and one showed a little improvement immediately after the operation, but the attacks returned. In every case, however, the attacks recurred after a lapse of several months. Sachs claims that the excision of cortical tissue of the diseased area is not superior to the older method of simple trephining, though a focus of disease may be the actual cause of epilepsy. Epilepsy, as a rule, does not manifest itself until widespread changes have appeared throughout the entire brain. If, therefore, we operate upon cases which have run a course of many years, removal of the initial focus of disease will have little effect upon the general sclerosis that has been established. He, therefore, suggests prompt surgical interference in all cases of injury to the skull where there is any reason to suppose that harm has been done to the brain, and also in those cases where a localized hemorrhage of traumatic origin, is more than likely to give rise to epilepsy; later on, excision of the cortex seems a questionable method. If patients could be promised a freedom from future attacks, excision might compensate for the paralysis caused by such excision, but such a promise can scarcely be given except in the most acute cases. Although the prospects for much benefit are gloomy, yet, considering the seriousness of epilepsy and the slight danger attending the opening of the skull, Sachs believes it the surgeon's duty in every case in which there is a shadow of doubt about the effect of an injury to the skull or brain, to trephine the skull and thus remove the cause of an epilepsy about to be developed.—*Boc. Med. and Surg. Jour.*

A CHICAGO SURPRISE.—Lakeside—So Winkle has lost his wife.

Whistler—Dear me! Who has got her? Lakeside—Death.

* Deutsche Med. Wochenschr., June 8, 1892.

† Amer. Med. Jour. of the Med. Sciences, November, 1892.

Exophthalmic Goitre.

P. J. Möbius, (*St. Petersburg Med. Wochenschrift*) has collected the main symptoms occurring in this disease from the widely distributed literature on the subject:

1. Examinations of the eyes shows exophthalmus, unusual space between the lids (Stellwag's sign), retardation in the movement of the upper lid (Graefe's sign) insufficiency of convergence, frequent paralysis of the ocular muscles of an intra-cerebral character, tremor of the eyelids and nystagmus.

2. Examination of the heart shows increase in frequency, systolic murmurs at base of heart, cardiac weakness and angina pectoris.

3. Enlargement of the thyroid gland may precede the other symptoms by years.

4. The skin shows diminished resistance to the electrical current (Vigoureaux), vitiligo, pigment spots, urticaria, a bronze coloration of the skin, redness, increased perspiration, loss of hair, and oedema of the lower half of the body.

5. Increase in the number of respirations, and cough; diminished distension of the chest after respiration, painless diarrhoea without a demonstrable cause, vomiting, bulimia, icterus, atony of the intestines and amenorrhoea.

6. Fever is observed in all stages of the disease; it may be ephemeral, remittent or intermittent; anæmia, and emaciation may be present.

7. The nervous symptoms are tremor, paraplegia, cramps, muscular atrophy, and disturbances of the mind.

8. The disease may be complicated with epilepsy, hysteria, paralysis agitans, glycosuria, polyuria, tabes, myxœdema, or syringomyelia.

9. Regarding the frequency of the individual symptoms, palpitation of the heart and swelling of the thyroid gland are never absent; pallor, emaciation, tremor, Stellwag's sign, and increased moisture of the skin are almost never absent; Graefe's sign, insomnia, and sensation of heat are frequent; pigmentation of the skin, diarrhoea, vomiting, insufficiency of convergence, and increase in the number of respirations, are often present. The disease is more frequently observed in females in the middle period

of life. Etiologically, a neuropathic disposition is of the greatest importance; then follows rheumatism, influenza, climatic changes and traumatism. The course of the disease varies; remissions are frequent and cures questionable.

10. Pathological anatomy has disproven disease of the sympathetic as a cause of the affection. Superficial hemorrhages in the floor of the fourth ventricle have been observed in a few instances; there has also been observed enlargement of the thymus and lymph glands.

11. Therapeutically, besides such remedies as iron, arsenic, belladonna, bromide, etc., electricity, applications of water, and extirpation of the thyroid gland may be mentioned. Regarding the latter, Lemke says, "that patients with exophthalmic goitre belong not to the physician but to the surgeon." Möbius attributes the disease to a primary affection of the thyroid gland of toxic origin.

Medical Events.

Chloroform discovered by Guthrie of New York, 1831.

Pasteur's experiments in the line of germ culture, 1870-90.

The first naval hospital founded on the ship *Dreadnaught*, 1821.

The first grand international medical congress held at Paris, 1867.

Morphia discovered in opium by Senturmer; claimed by others, 1803.

Dr. Richard Bright published his researches on diseases of the kidneys, 1836.

Miss Garrett licensed in London to practice, the first female licensed doctor, 1865.

Vaccination made compulsory in England in 1853; in Ireland and Scotland in 1863.

The Bellevue Hospital, New York, founded and opened, with 800 beds for patients, 1826.

Vaccination generally practiced all over Europe. Anti-vaccination societies begun in 1816.

The ophthalmoscope invented by Helmholtz. Revolution in treatment of eye disease in 1851.

Farraday's discovery of inductive electricity opened a new era in the history of medical electricity, 1831.

Lectures on medical jurisprudence first delivered in America at Columbia College by Dr. Stringham, 1804.—*Med. Bull.*

THE LIBRARY TABLE.

Manual of Bacteriology. By George M. Sternberg, M. D., Deputy Surgeon-General, U. S. Army; Director of the Hoagland Laboratory, Brooklyn, N. Y., etc. Pp. 886. William Wood & Co., N. Y.

The appearance of a masterly work on bacteriology from the pen of an eminent American scientist will be greeted with delight by all American students and physicians. This work comprises both manual and text book in which can be found a carefully written description of about four hundred species of bacteria, and a detailed account of the technique necessary in bacteriological investigations. The work, as would be expected, is largely a compilation, but it brings into accessible form the best results of bacteriological research that have been obtained especially by European investigators. Perhaps the severest criticism that can be made on this work is the omission of a reference to a large amount of excellent work that has been done in the various laboratories in America.

The subject matter is divided into four parts: The first part treats of the history, classification and morphology of bacteria together with the technique. The methods given are well selected and reasonably condensed. This part includes also a chapter on experiments with animals, and one on photographing bacteria. The second part contains thirteen chapters on general biological characters of bacteria, including an account of the action of antiseptics and germicides. This chapter contains many valuable facts and is of special interest to physicians on account of its discussions of the ptomaines, toxalbumins, etc. The third and fourth parts are devoted to pathogenic and saprophytic bacteria respectively. The descriptions and illustrations of the more important bacteria are quite elaborate, while the description of the non-pathogenic and partially described pathogenic forms are given in small type thus adding data while saving space. The bibliography is extensive and arranged under appropriate headings. Although the book is rather large it is as small as the subject would permit. If more could have been added with profit nothing could have been admitted without injury. The work deserves a careful perusal by all who are interested in bacteriology, hygiene and medicine.

Text Book of Nervous Diseases. By Charles L. Dana, A. M., M. D. With 210 illustrations. Pp. 524. New York: William Wood & Co., 1892.

The work before us is one well worthy of commendation, and as far as its limits will permit, represents in a condensed form the state of our knowledge of Diseases of the Nervous System. Sufficient space is devoted to the Anatomy and Physiology of the nervous system to make the information serviceable in the consideration of its various diseases.

The work is divided into five parts. Part I., which is subdivided into five chapters, gives a general description of the nervous system, its anatomy and diseases, including diagnosis and methods of examination, treatment, hygiene, etc.

Part II. gives the anatomy and diseases of the Cranial Nerves. Considerable care has been taken to present a clear general view of the diseases of the Optic Nerve and Centers, as well as the motor nerves of the eye. It is an encouraging sign of the times that books on nervous diseases, intended for the student and general practitioner, embrace fuller descriptions of the diseases of the nervous apparatus of the eye and its adnexa, than the older writers gave. The important part which anomalies of refraction, accommodation and ocular muscular equilibrium play in the causation of certain reflex nervous disorders is being more fully recognized, and it is pleasing to find in the present work so large an amount of intelligible and useful information upon this branch of the subject. The purely optical considerations are very properly left for special treatises. In our opinion the study of the eye and its diseases should not be entirely relegated to the ophthalmologist. As the standard of medical education is raised, we hope to find the general practitioner as well acquainted with the eye and the ophthalmoscope, as he is with the chest and the stethoscope. The ophthalmoscope in modern medicine is indispensable for purposes of diagnosis. How often the indications of cerebral and other diseases, previously unsuspected, have been revealed by an ophthalmoscopic examination of the fundus oculi.

Parts III. and IV. are devoted to the anatomy and diseases of the spinal cord and brain, and Part V. treats of functional nervous diseases.

It is evident that no pains have been spared to make a general knowledge of the subject of neurology as easy of acquirement as possible, and to this end many useful tables are scattered throughout the work. The author's style is smooth and clear. The printing is well executed. The 210 illustrations, some of which are colored, help greatly to elucidate the text.

Physiology. By Frederick A. Manning, M. D., Attending Surgeon, Manhattan Hospital, N. Y. Students Quiz Series. Series edited by Bern B. Gallaudet, M. D., Demonstrator of Anatomy, College of Physicians and Surgeons, New York; Visiting Surgeon Bellevue Hospital, New York. Philadelphia: Lea Bros. & Co. Price \$1.00.

Of necessity, a quiz compend must follow beaten paths, and the volume under consideration is no exception to the rule. It is uniform with the other volumes of the series and arranged in the form of question and answer. In common with all such works it is useful only as a means of refreshing the

memory—as a text book it is worthless. The author claims no originality, having drawn on the works of Dalton, Foster and others. In an appendix, a table of the development of the embryo, modified from Gray's ana-

tomy; a concise description of the chemical tests used in physiological analysis, and a comparison between the metric and English systems of measurement are arranged in such a way as to simplify the student's work.

CURRENT LITERATURE REVIEWED.

THE ANNALS OF GYNECOLOGY AND PÆDIATRY FOR FEBRUARY

contains an article by Dr. W. A. Briggs on the

Septic Origin and Antiseptic Treatment of Chronic Endometritis.

The causes of the disease are divided by the author into two divisions, active and passive. Besides infection no other active cause exists, all others—traumatism during abortion or parturition, the recumbent position during child bed, etc.—being passive. In the treatment the strictest antiseptic rules are to be enforced, even to the interdiction of sexual relations which may be a possible source of infection. Antiseptic douches are to be used twice daily, the author preferring to alternate the bichloride of mercury solution with a creolin solution on account of the danger of mercurial poisoning. The author is a firm believer in the efficacy of intra-uterine injections, using a solution of iodine and camphor in creosote. This, he thinks, is less apt to cause uterine colic than tincture of iodine, though he acknowledges that pain occasionally follows its use. Electricity he also considers a valuable agent in the treatment of endometritis, using the combined Faradic and Galvanic current when the uterine cavity is enlarged and the muscle flabby. In hypertrophic and hemorrhagic endometritis he advises the irrigating curette. Displacements, by causing stagnation of the circulation, aggravate the disease and should be corrected. Should the support of a tampon be necessary, he employs cotton soaked in glycerole of tannin.

Dr. O. B. Will in a paper on

Conservatism versus Radicalism in the Treatment of some Forms of Pelvic Diseases in women.

presents the non-operative side of the question. He justly attacks the men operating on any and the slightest indications, but at times the article becomes radical in its conservatism. "Diagnostic skill," he says, "is the first requirement and may be gained, in the majority of instances, without the assistance of ante-mortem or post-mortem dissection." Yet, he describes a case where he performed a laparotomy and ruptured a thin cyst of the ovary in a woman who had been treated for neuralgia of the ovary. Where did his diagnostic skill come from?—probably previous sections. Electricity is given a front rank in the treatment of pelvic troubles and he departs from the advice of Apostoli to withhold the electrode in the presence of pus,

for he says "If after half a dozen *seances* there is developed no constantly increasing improvement—as evinced in lessened pain, tenderness and general irritability—I conclude upon further investigation into the probability of existing suppuration." Should not his first requirement, diagnostic skill, have been exercised earlier—before the application of an agent which all agree is most potent for harm in just this condition? Pyosalpinx is cured by catheterization of the tube and the injection of peroxide of hydrogen. "Daily or alternate-day applications of this character will soon put the parts in a healthy condition, pus or no pus." Should, however, both ends of the tube be closed and its walls distended with pus, then laparotomy is the only relief at the present time. As an example of conservatism "glued fast" the paper is an excellent one.

Dr. E. W. Cushing reports

Some rare forms of Myomata

removed by him. In one instance the ureters were found drawn up on the sides of the tumor. During the operation one ureter was cut, but the reporter was enabled to unite the severed ends by fine silk sutures. A urinary fistula resulted which promptly closed. The report is illustrated by excellent photographs of the tumors removed.

Dr. Charles P. Noble contributes an article on "Vaginal Hysterectomy for Cancer," with report of four cases, which has already appeared in abstract on page 147 of THE MEDICAL AND SURGICAL REPORTER.

In the department of Pædiatry is an exhaustive paper on "The Diagnosis of the Meningitic Form of Enteric Fever in Children" by Dr. Georges Georgevitch, translated by Dr. Charles Greene Cumston. Typhoid fever in children is discussed and the similarity between tubercular meningitis and typhoid fever with pronounced brain symptoms pointed out. The differential diagnosis is considered and cases reported illustrating the various points under discussion.

THE MEDICAL BULLETIN

For February contains an article by Dr. John V. Shoemaker on

The Therapeutical Applications of Cocillana.

The chief use of the drug is in diseases of the respiratory tract, chiefly bronchitis, as it stimulates the capillary circulation of the bronchial mucous membrane, thus relieving inflammatory congestion. Cocillana may be administered in the form of the tincture or

fluid extract; though the author prefers the fluid extract, in doses of ten to twenty minims, combined with syrup. The paper includes the report of cases of bronchitis, influenza, hay fever and tuberculosis which were cured or relieved by the use of the drug.

Dr. John B. Brooke contributes a paper on

The Internal Use of Aristol

which he thinks saved the life of an infant suffering from enterocolitis. He administered the drug in $\frac{1}{2}$ grain doses every two hours, combined with Dover's powder and sugar of milk. Since using it in the above case, which is reported in full in the paper, he has employed it with marked benefit in typhoid fever, dysentery and simple diarrhoea. He has not met with a case where the stomach would not tolerate it and advises its use especially where there is a muco-purulent discharge.

Dr. Edward C. Mann discusses the "Clinical Observation of Diseases of the Brain and Nervous System" in an article taken from the advance sheets of his work on Medical Jurisprudence. The question of localization of lesions of the brain and spinal cord is fully entered into, and the value of the ophthalmoscope in the diagnosis of diseases of the nervous system pointed out. The paper will be continued in the next issue of the journal.

Dr. J. Y. Hoffman reports a case of "Congenital Obstruction of the Bowels" where the post mortem revealed "an obstruction in the intestine about twenty-five inches from the pyloric orifice of the stomach, completely occluding the intestine. The mass was of a greenish blue color, of semi-solid consistency, adhesive in character." The intestine below was normal but had never been distended. A number of these masses were found but none occluded the intestine or were as firm in consistency as the first.

This number concludes with a clinical lecture by Dr. E. E. Montgomery on "Enucleation of Fibroids; Fibroid Tumors; Plastic Operation on the Pelvic floor; Vaginal Hysterectomy."

THE THERAPUTIC GAZETTE.

The February number contains seven original communications. "The Treatment of Acute Laryngo-Tracheitis" by Dr. Zeiss; "Salicylates in the Treatment of Pleurisy with Effusion" by Dr. Dock; "The Treatment of Incomplete Abortion" by Dr. Davis, are the more prominent articles. Dr. Kyle in a paper on

Resterilized Sponges, with Bacteriological Investigation,

states that the question of what is the best sponge to use in surgical operations still remains unsettled, some surgeons preferring the sponge, others the bichloride gauze. The sponges used in making this examination had been used in a septic case. They were resterilized by soaking twenty-four hours in bicarbonate of sodium solution, and then placed in carbolic acid solution (strength five per cent.) for one week. Some of the sponges were large and flat—elephant-ear sponges—while the others were thick and firm in the

centre. Tubes were inoculated from each by taking from the outer layer of the sponge a small portion and placing this in the agar-agar tube; then cutting the sponge open, a small portion was taken from the centre.

The flat thin sponges showed no growth. With the thick sponges the experiment from the surface gave negative results; but from the thick, firm centers—from eight different inoculations, in from two to five days, at a temperature of 80° F.,—each showed marked growths. Stains made from these tubes showed numerous bacteria. By the process of isolation the micro-organisms of suppuration were found. The sponges were left in the carbolic acid solution for six weeks. Then inoculations made as before, gave practically the same results. The thick sponges were subjected to pressure while in the fluid, and inoculations made showed no change as to results. In making these experiments the same precautions were taken as would be necessary in any antiseptic or aseptic operation. The inoculating needles, forceps, scissors, etc., being sterilized in a steam sterilizer, and the experimenter's hands being prepared by soap, water and brush,—special attention being given to the cleansing of the nails—then washing in bichloride solution (1 to 1000). In each case satisfactory check experiments were made, which proved that the infection did not come from any want of antiseptic precautions during the experiments.

THE SEI-I-KWAI MEDICAL JOURNAL

Is edited and published by the Sei-i-Kwai, or Society for the Advancement of Medical Science in Japan. The December issue contains three original articles in English and four in Japanese.

"Report on the Treatment of Ovarian Cysts" by Dr. Yoshida; "Sketch of the Process of Manufacturing Camphor in Japan;" "Immunity from Leprosy of the fifth generation and Non-Contagion" by Dr. Ashmead are the English articles.

It is interesting to learn from Dr. Ashmead's paper on

Immunity from Leprosy of the Fifth Generation

that there is a fact which bears very directly and very strongly upon the subject of the non-contagiousness of Leprosy. It is recognized by all Oriental leprologists that every child of a leper has an inheritance of the disease but diminished, and that after the fourth generation, if no healthy blood intervenes, the disease is entirely extinguished. There is about these matters a very interesting law in China and consequently in Japan, the latter being, in spite of its western civilization endeavors, much more submissive to Chinese traditions than to European ideas.

"No marriage with children of leprous parents is allowed. If leprosy appears in a family formerly clean, all betrothals and contracts of marriage previously entered into, are rescinded as a matter of course. Only when the betrothed or married persons suffer of the same degree and type of leprosy, for

instance, both of the fourth degree of generation, the alliance stands. Only equal degrees of age of the morbid cases are allowed to connect themselves by marriage. A leper of the fourth generation, even if he no longer shows any external marks of the disease, can only marry a woman of the same degree of age of the disease: their offspring is free from leprosy and no longer forbidden human intercourse."

Here we have then a perfect immunity acquired in four generations, and the fifth generation restores the health of the race. There is certainly a connection between this extinction of the disease and the present immunity of Europe when that part of the world had been a prey to leprosy during several centuries of the middle ages. Evidently in the West, simple isolation has unconsciously accomplished, in the lapse of time, what a rational legislation tries to bring about in the East. The legislation has probably preserved the populations of China, and of the East in general, from entire destruction. I do not mean to say that the rule is always and carefully adhered to, because, in that case, the disease would be extinct now: but the rule is sufficiently known, and sufficiently adhered to, to make its salutary consequences felt.

THE MEDICAL REPORTER.

The January issue of *The Medical Reporter of Calcutta* contains an interesting article on

The Treatment of Tuberculosis with Tuberculoïdin.

Speaking of the preparation of Tuberculoïdin Prof. Klebs states that it can be prepared in various ways, but it is a common feature of all methods that the substance precipitated from crude Tuberculin by platinum chloride and so-called alkaloidal re-agents, contains the injurious substances of the remedy, while the albumose, remaining under this treatment in solution, which can be thrown down and purified by alcohol, forms the remedial agent of the crude Tuberculin. This preparation brings about no disturbance in the evolution of heat by healthy animals, and is altogether free from the action on the heart which is peculiar to crude Tuberculin, as well as to the substances thrown down from it by platine and other salts.

All these injurious effects, to which in human beings a long list of direct lesions of the nervous system have been added, are avoided by the application of the purified remedial albumose "Alexin" or Tuberculoïdin. Very large doses of the latter, up to one-third grain *pro die* are of course followed by disturbances in many patients, specially manifested in a more or less troublesome feeling of weariness as well as in further emaciation in the earlier stages of the treatment; this, however, in favorable cases is made up later, and indeed, often gives place to a very evident gain of weight.

From this therefore it is seen, that Tuberculoïdin though free from the dangerous by-effects of crude Tuberculin, can by no means

be regarded as an indifferent substance. Further it is also clear that it is not merely a diluted Tuberculin: Tuberculoïdin constitutes about 2½ per cent. of the crude Tuberculin, and if it were only a dilution of the latter, volumes of the two bearing the respective proportions to one another of 40:1 should produce the same action. As the quantity of 1½ grain Tuberculoïdin—attained after a few doses in tuberculous human beings—produces no fever, whilst crude Tuberculin in these subjects; in a dose of ½ grain often brings about a very considerable rise of temperature as Dr. Robert Koch, among others, has established by alternate injection of the two substances, is clear that the action of Tuberculoïdin and Tuberculin is quite distinct.

The article goes on to consider "The action upon the Tubercle Bacillus," etc., to be concluded in another issue.

Dr. Banerjee has a paper on "Ophiology or a description of the Snakes of India," "Topical Dysentery" by Dr. Day, and "Unique cases of Paresis" by Dr. Shah, of Junagadh, conclude this number.

THE PRACTITIONER.

The January issue contains an interesting paper by Dr. Wilks, on "The Value of Drugs." He calls attention to the uses of Iodide of Potassium, the Bromide of Potassium; Exophthalmic goitre, or Graves' disease, cured by Belladonna; the value of Arsenic in Idiopathic Anæmia, the cure of Tuberculosis peritonitis and Dysentery and Chronic Diarrhoea. This paper contains no novelties; it is merely an expression by one, who has had a long experience, of his conviction of the value of drugs.

Dr. Duckworth has an article "On Some Matters Relating to Dietary for the Sick."

"Gout of the Intestines; its Pathology and Treatment" is offered by Dr. Haig. A continued article "Passive Congestion of the Lungs from Heart Failure" by Dr. Morison is concluded in this number.

"The Treatment of Myxedema" by Dr. McCall Anderson will be found quite instructive. The principle treatment consisted of the administration by the mouth of thyroid juice. Eighty minims (two-thirds of extract of one thyroid) was used. A fourth part of this was given on four consecutive days after which an interval of three days elapsed before any more was administered. Five days after the treatment was commenced showed marked improvement which continued on uninterrupted until at the end of four weeks, when the patient expressed the opinion that she was quite well. A set of photographs illustrating in a striking manner the change in the appearance of the patient accompany the article.

Acute Laryngitis in Children.

R Ammon. muriat. grs. xvi.
Ext. prun. virg. fl. ʒiiss
Aq. menth. pip., q. s. ad. ʒij

M. Sig.—Teaspoonful every two hours.

—Lancet Clinico.

PERISCOPE.

OBSTETRICS.

Measuring the Pelvic Outlet before Labour.

Tarnier (*Jour. des Sages-Femmes*, October 16th, 1892) recently gave a clinical demonstration respecting a case of dorso-lumbar kyphosis. The patient was hump-backed, the prominence being low down; in such cases the pelvis is nearly always transversely contracted, forming the funnel-shaped pelvis. In this patient the pelvic inlet was enlarged; measurement was very easy. On the other hand, the outlet was, as usual, very difficult to measure. No compass or pelvimeter gives precisely the distance between the tuberosities of the ischium. The best plan is to place the patient on her face with the nates raised. The obstetrician places his hands outside the tuberosities, the thumbs being pressed against those prominences. An assistant then measures the distance between the thumb-nails. It is normally 2½ inches. In Tarnier's patient it was but 2 inches. With the aid of forceps labour was terminated without difficulty, and mother and child fared well.—*Br. Med. Jour.*

GYNECOLOGY.

The Frequency of Local Symptoms of Uterine Displacement.

Dr. Herman gave the results of some 407 observations made by him with the object of determining the relative frequency of the local symptoms associated with retroflexion or retroversion of the uterus. He discussed the two displacements together, no great importance attaching, in his opinion, to the distinction between them.

He found that *chronic pain* of some kind was present in nine-tenths of cases of backward displacement of the uterus. The most frequent seat of pain was the back, generally the sacral region. Next most often came sensations of descent, and uni-lateral pains, mostly in the ovarian region, cases of left-sided pain outnumbering those of right-sided pain in the proportion of three to one. In a short proportion lower abdominal pain was the chief complaint, and in a very small minority trouble in locomotion was the prominent symptom.

Pain in defecation was present in less than half the cases. In the majority of the cases in which it was present it was accounted for either by constipation or by morbid conditions of the rectum. The author estimates the proportion of cases of backward displacement of the uterus in which the displacement is the sole cause of painful defecation at about one in nine.

Backward displacement of the uterus had no appreciable effect as a cause of *painful micturition*; but *bladder irritation* due solely to the displacement was present in about one case in five.

Leucorrhœa was not commoner in cases of

backward displacement of the uterus than other patients.

Dyspareunia was present in at least one-sixth, and probably in a larger number; absent in at least one-seventh.—*Med. Weekly, Paris.*

NEWS AND MISCELLANY.

Another Four Year School.

The Woman's Medical College of Pennsylvania now requires all new matriculates to take four annual courses of graded instruction before being eligible for graduation. This is an evidence of the rapid progress made by the movement to elevate the standard of medical education.

American Surgical Association.

The preliminary programme for the meeting to be held at Buffalo, N. Y., May 30, 31, and June 1, 1893, is as follows:

President's Address.

1. The Modern Treatment of Compound Fractures. By Dr. Nicholas Senn, Chicago. Discussion by Drs. Roswell Park and F. S. Dennis.

2. Hypertrophies and Degenerations of Cicatrices and Cicatricial Tissue. By Dr. J. Collins Warren, Boston. Discussion by Drs. C. H. Mastin, G. R. Fowler and W. H. Carmalt.

3. Surgery of the Gall Bladder. By Dr. M. H. Richardson, Boston. Discussion by Drs. J. Ewing Mears, A. Vander Veer, W. H. Carmalt, and Theo. A. McGraw.

4. Surgery of the Rectum. By Dr. A. G. Gerster, New York. Discussion by Drs. L. S. Pilcher, H. H. Mudd, and L. McLane Tiffany.

5. Surgical Treatment of Cervical, Thoracic and Abdominal Aneurism. By Dr. C. B. Nancrede, Ann Arbor. Discussion.

6. Surgery of the Prostate. By Dr. J. William White, Philadelphia. Discussion by Drs. Hunter McGuire, T. F. Hewitt, R. F. Weir, and F. H. Gerrish.

7. Treatment of Carbuncle. By Dr. F. Lange, New York. Discussion by Drs. Robert Abbe, J. B. Roberts, and J. S. Wight.

In addition to the above specially selected subjects, the following papers have been offered:

1. Unreduced Dislocations of the Astragalus. By Dr. Stephen Smith, New York.

Fellows who propose to present volunteer papers are requested to send to either of the undersigned the titles of their proposed papers as soon as possible, in order that they may be properly classified and arranged for the final programme.

Fellows are also requested to notify the Chairman of the Committee whether they will take part in the discussion upon any of the special subjects given in the above list.

Nicholas Senn, President, J. R. Weist, Secretary, J. Ewing Mears, Recorder, F. S. Dennis, John S. Billings, Business Committee.